DOCUMENT RESUME

ED 148 058 EC 103 366

AUTHOR Kenny, Carolyn, Ed.
TITLE Music Therapy Evaluation Study for Department of Health and Welfare Demonstration Projects.
PUB DATE [76]
NOTE 223p.; The project was conducted by the Extempora Music Society of Vancouver

EDRS PRICE MF-$0.83 HC-$11.37 Plus Postage.
DESCRIPTORS *Demonstration Projects; *Emotionally Disturbed; Exceptional Child Research; *Handicapped; Inservice Education; Institutes (Training Programs); *Music Therapy; *Program Evaluation; Workshops

ABSTRACT

Reported are the findings of a project to evaluate the effectiveness of music therapy with disturbed or otherwise handicapped individuals in a number of different clinical settings. Following an introduction which outlines the project's objectives, a brief section discusses research methodology. The remainder of the document includes a larger section on the training workshops that were held, and their outcome, and five sections corresponding to the various institutional settings: the Dayhouse (a daytime treatment center for neurotic patients); Daycare (a daytime supportive program for patients more severely disturbed than those in the dayhouse program); Vancouver Neurological Centre (a private society which provides coordinated treatment for all types of neurological impairment, such as physical, social, and emotional complications); Barnaby Mental Health Centre (a daytime treatment program for emotionally disturbed preschool children); and Preschool for Special Children (documentation for this setting is explained to be in a film available from the University of British Columbia). Reported among findings are the following: evaluation procedures showed no measureable effect of music therapy as a treatment medium; participants of music therapy training workshops did gain an understanding of music therapy as a treatment technique; and all of the agencies in which music therapy was offered were anxious to maintain their program. (SBH)

****
* Documents acquired by ERIC include many informal unpublished *
* materials not available from other sources. ERIC makes every effort *
* to obtain the best copy available. Nevertheless, items of marginal *
* reproducibility are often encountered and this affects the quality *
* of the microfiche and hardcopy reproductions ERIC makes available *
* via the ERIC Document Reproduction Service (EDRS). EDRS is not *
* responsible for the quality of the original document. Reproductions *
* supplied by EDRS are the best that can be made from the original. *
****

ED148058

U.S. DEPARTMENT OF HEALTH,
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION

THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY

MUSIC THERAPY EVALUATION STUDY

for

Department of Health and Welfare

Demonstration Projects

Research Consultant: Brian Campbell

Research Assistant: Wendy Tobin

Edited by : Carolyn Kenny

EC103366

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY

Extempora Music
Society

TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC) AND USERS OF THE ERIC SYSTEM."

TABLE OF CONTENTS

I Introduction 1

II Research Methodology 5

III Music Therapy Training Workshops - Diary Compilation 9

IV Dayhouse 82

V Daycare 111

VI Vancouver Neurological Centre 158

VII Burnaby Mental Health Centre 193

VIII Preschool for Special Children 215

(Each section of the report has its own appendices)

I

INTRODUCTION

I. Introduction

This report is the documentation of the music therapy programme conducted by the Extempora Music Society under the sponsorship of a National Health and Welfare Demonstration grant. The original proposal had five objectives:

a) to conduct music therapy in a number of clinical settings;

b) to evaluate the effectiveness of music therapy as a form of treatment;

c) to encourage and educate other professionals in the use of music therapy by conducting workshops in music therapy;

d) to stimulate agencies and local sources to finance the continued use of music therapy and to incorporate music therapy into their regular treatment programme;

e) to attempt to get training courses in music therapy established in Vancouver.

The report is divided into a number of sections corresponding to the various institutional settings in which music therapy was conducted, and a larger section on the training workshops that were held, and their outcome. This introduction will summarize the major findings in each area.

The evaluation of the effectiveness of music therapy in a number of different clinical settings was the most difficult part of the report. These sections have both a hard and soft data component. The psychometric tests that were used, as well as the other standardized test, showed no measurable effect of music therapy as a treatment medium. On the other hand, patients were generally enthusiastic about the music therapy sessions, and the staff in the various institutions considered music therapy an important addition and contribution to their treatment programmes. The inability of traditional research tools to detect shifts in patients as a result of use of music therapy is partly a result of the state of the science, partly the limited resources, and partly the fragmented nature of the project. These various areas will be discussed in the section on methodology.

The report however provides sufficient data to indicate the possible effectiveness of music therapy, and attempts to begin the process of systematizing the possible situations and types of patients for which it is most effective.

In addition to the written material presented in this report, a series of videotapes and films have been prepared to give an even deeper insight into the functioning of the music therapy. A film showing the work of music therapy professionals was produced at the Centre for Exceptional Children. The music therapists worked at this Centre prior to the Health and Welfare Demonstration Grant. Although they were unwilling to participate in the research, they wished the music therapy to continue and willingly agreed at a later date to the film being produced. The film is approximately seventeen minutes in length.

Also, all the sessions of one music therapy workshop were videotaped and edited into a two hour long videotape on the workshops. Other videotapes were made on music therapy sessions at Dayhouse, Daycare, and Burnaby Mental Health Preschool Plus. The tapes from Burnaby are publically available but the tapes from Dayhouse and Daycare are only available through the UBC Health Sciences Centre to psychiatric professionals and students attached to the Centre.

The music therapy training workshops introduced approximately 120 mental health workers to the techniques of music therapy. The largest number of people attending these workshops came from the institutions in which the music therapists were working. Initially the workshops were intended to provide people with the tools which would enable them to use music therapy in their work situation. The evaluation indicates that this goal was overly ambitious, and, in fact, a relatively small number are using music therapy in any thorough way in their work. However, the participants did gain an understanding of music therapy as a treatment technique. For many of them, music therapy was personally significant; and, there was a great deal more interest in integrating music into their treatment programmes. Most indicated either in the questionnaires or the follow-up interviews that were conducted with four groups of participants, that they were anxious to have additional training and on-going support in using music therapy.

All of the agencies in which music therapy was offered are anxious to maintain it in their programme, while many new agencies whose staff took the workshop training are anxious to introduce it. Funding has proved to be a major obstacle, with virtually all of these institutions having committed their financial resources to existing programmes, and using any increase in funds for the next fiscal year simply to cover salary increases. In addition, many of these institutions have had their government funding cut back because of the current austerity programmes being conducted by the federal and provincial governments.

The final objective has been very successfully achieved. Capilano College, through its Music and Psychology Departments, is sponsoring a music therapy course, starting in the fall of 1976. The impetus and the initial development of this program was the result of the activities of the two music therapists, both at the College and within the general psychiatric community. Both music therapists will be teaching part-time in this programme in the fall.

This report along with the videotape and film productions constitute a wealth of information and material that can be used in training music therapists as well as the basis for future research.

II

RESEARCH METHODOLOGY

II. Research Methodology

A major debate has raged in the field of psychotherapy evaluation since the 1952 publication of Eysenck's paper summarizing the state of psychotherapy research, and pointing to the lack of evidence existing for the effectiveness of various psychotherapy techniques. He generally found that there was evidence for a "spontaneous remission" rate that approximated the rate achieved for patients who had undergone treatment. This is supported by previous studies by Bergin (1963, 1966) and Gurin, Veroff and Feld (1960) which found that the majority who seek help for personal problems or psychological disturbances do not go to mental health professionals. He was highly critical of the sloppiness of research in this area and suggested the "necessity of properly planned and executed experimental studies in this field" (p. 323). As could be expected, this paper triggered a controversy within psychology and psychiatry that has not yet been resolved.

In a later publication, he concluded that not only was there no evidence for the success of psychotherapy, there was evidence that patients had a lower rate of recovery than those who had received no treatment. He cited three studies with proper control groups - the Teuber and Powers (1953) study of the effects of psychotherapy on preventing delinquency; the Brill-Beebe Study (1955) on the effect of treatment or non-treatment of War Neuroses; and the Barron and Leary (1955) study of 150 psycho-neurotic patients which showed that there was no significant difference between those who received treatment and those who were on the waiting list to receive treatment.

Bergin (1971), in his more recent overview of the literature, re-examines the studies on which Eysenck based his original report, and, by removing the drop-outs and including the partially improved with the improved categories, demonstrates that the recovery rate is higher, and, in some cases, substantially higher, than Eysenck claimed. Bergin also disputed the spontaneous remission rate of 70% remarked by Eysenck, claiming that much of it could be explained by therapeutic contact with friends, therapeutic non-professionals such as ministers, spouses and teachers, and other acquaintances. Eysenck showed that about two-thirds of all neurotics who enter psychotherapy improve substantially within two years, and that an equal proportion of neurotics who never enter therapy improve within an equivalent period.

Bergin also claims, on the basis of a number of studies, that the spontaneous remission rate is probably closer to 30%. He, however, pointed out that the idea of such an abstract base-line is worth very little. The question of the rate of recovery as the result of various treatment is still unclear. As Bergin points out, very small shifts in the interpretation of the data can substantially affect the outcome.

He recommends, and there appears to be some evidence that this direction is being taken, that research be much more specifically oriented, rather than oriented to general outcome.

In this evaluation, attempts were made to document data about the actual use of music therapy as a treatment method without focussing specifically on outcome alone. As already indicated, any assessment of outcome as far as the effectivenss of music therapy is concerned has been extremely difficult to ascertain. Extensive documentation of use of music therapy has however been provided for each of the treatment settings in which it was used.

III

MUSIC THERAPY WORKSHOPS

Music Therapy Training Workshops

Five separate introductory music workshops were conducted under the sponsorship of the Health and Welfare Demonstration grant. In all, 122 participants were involved in them. Also, one further workshop was held for people who had previously completed a workshop and wanted more training. Other short workshops were conducted in the various treatment centres in which the two music therapists were working, in order to acquaint the staff with music therapy.

This section of the report concentrates on these five introductory workshops. The first workshop was composed of five sessions, while the remaining four were lengthened to six sessions in response to requests for more discussion time. These requests were stated in the evaluation questionnaires completed at the end of the first workshop.

Data from each of the workshops was collected through a series of questionnaires: an initial questionnaire completed before the workshops began; a follow-up questionnaire presented immediately after the first session; and a final follow-up conducted three months later. In addition, all participants were expected to keep diaries of their responses to the workshops. Participants were asked to describe their mood when they came to the workshop sessions, their responses to the various activities in which they were involved there, and which they thought could usefully be used in their work situation.

Diaries in the first three workshops were handed in at the end of the workshops, but in the last two they were turned in in installments at the beginning of each next session. These diaries were used to assist the therapists in understanding the responses of the workshop participants, and as an aid in planning. They were also used by the researchers to give additional information with which to interpret the questionnaire results, especially the sections on response to the various activities.

Reaction to the questionnaires was mixed. Many people however felt that the questions overlapped each other. Not surprisingly therefore, many did not recognize or respond to the subtle distinctions between many of the questions, and fewer questions could therefore have been used just as profitably. According to the music therapists themselves, and borne out by several remarks made on the questionnaires, many of the participants regarded them as unnecessary and undesirable intrusions into the workshops. This response is not uncommon, as Gibbs points out in his summary of human relations training research. Both therapists and participants take it as given that the event is valuable for itself, and therefore further investigation is unnecessary.

Regular attendance was kept on workshop participants after the first workshop. Table 1 gives a breakdown of the attendance at the workshops for which we have records.

Attendance at the workshops was quite high throughout the sessions, until the last two, especially when you consider that many participants were working shifts throughout the workshops. But it was during the last sessions that the participants were expected to lead music therapy exercises that they had developed themselves. Attendance was viewed by those who

Table 1. Attendance at Music Therapy Workshop Sessions

Workshop	Total Registration	Session 1	2	3	4	5	6	Final Q
1	19							14 (74%)
2	25	20 (80%)	23 (92%)	17 (68%)	17 (68%)	16 (64%)	13 (52%)	19 (76%)
3	15	11 (73%)	13 (86%)	11 (73%)	10 (66%)	11 (73%)	11 (73%)	12 (80%)
4	35	31 (89%)	24 (69%)	22 (63%)	26 (74%)	19 (54%)	15 (43%)	26 (74%)
5	28	25 (89%)	20 (71%)	22 (79%)	19 (68%)	18 (64%)	16 (57%)	23 (82%)
	122	87 (84%)	80 (78%)	72 (70%)	72 (70%)	64 (62%)	55 (53%)	94 (77%)

Detailed breakdown of attendance is contined in Appendix A.

filled out their diaries as very threatening, many commenting that they did not really want to attend, and were anxious until other people started to do their exercises. The anxiety level of those who attended probably explains the drop in attendance in the last session especially. Attendance at the fourth workshop was somewhat lower than for the rest. In their evaluation of the workshops many complained about the size of the group. This group was also the only one that was held in the evening on the staff's own time. Considering this, there is surprisingly little difference in this group from the rest.

Reasons for attendance and non-attendance at the workshops was tested against both music and occupational backgrounds. Neither factor had any significant relationship to workshop attendance. Where we were able to determine the causes of dropping out of the course in the fourth and fifth sessions, the major reasons given were weather, sickness, transportation and work shift problems, with one person having moved during the course of the sessions. Only one person admitted dropping out of the course because of anxiety about the workshops, the fact that they were non-musical or found the exercises personally threatening. Undoubtedly however, some of those who dropped out must also have been anxious about their personal involvement in music.

Supporting data for this interpretation is gained from the follow-up questionnaire. Almost every person coming to the workshops expressed some anxiety, nervousness or apprehension about the first workshop. This is clearly expressed in people's diaries also. Although most participants were able to relax in the warm-up exercises in the first session, for many anxiety and threat continued on specific occasions throughout the workshop. Later, in the section of this report dealing with those activities in which people felt threatened, it is clear that such apprehension was experienced in specific activities. It is safe then to assume that the drop-out rate is not simply explained by the various practical reasons that were given to the research assistant when she was attempting to get the follow-up questionnaires completed. This information however was not pursued systematically.

The age breakdown of those attending the workshops is shown in Table 2. The breakdown indicates that it was primarily younger persons who attended the workshops. There are two contributing reasons for this. First, the mental health and occupational therapy fields have only recently increased greatly and therefore their age composition tends to be younger than more traditional occupations. Secondly, younger staff members tend to be more open to, and have the energy to explore new treatment modalities.

Table 2. Age Breakdown of Those Attending Music Therapy Workshops

Workshop	Less Than 17	18-20	21-24	25-28	29-32	33-36	37-45	Over 45	Total
1			3	7	4	3	6	4	27
2			6	9	12	2	3	3	35
3			1	6	3	1	1	2	14
4		1	5	10	4	3			23
5			2	3	6	4	3	1	19
Total		1	17	35	29	13	13	10	118
		1%	14%	30%	25%	11%	11%	8%	100%

Eighty percent of those attending the workshops were female, twenty percent male. This reflects the overwhelming concentration of females in the mental health occupations, particularly in occupational therapy. Interestingly, of the seven physicians who attended the workshops, five were male.

Table 3 gives a breakdown of the mental health occupations represented at the workshops. Although there is a wide range of occupations represented, it is clear, for reasons to be explained later, that occupational therapists were the dominant group in attendance. This partly explains the weak therapeutic background of many of the participants, since a strong psychotherapeutic training would not be part of the educational

Table 3. Mental Health Occupations Represented at Music Therapy Workshops

Nurse	18 (15%)
Occupational Therapists	41 (34%)
Psychiatric Nurse	2 (1.6%)
Community Health Worker	14 (11%)
Social Worker	9 (7%)
Doctor (Psychiatrist)	7 (6%)
Activity Worker	9 (7%)
Physiotherapist	3 (25%)
Psych. Assist.	2 (1.6%)
Behavioural Therapist	1
Psychologist	1
Family Therapist	1
Speech Therapist	1
Assist. Prof. (Dept. of Education)	1
Audio-Visual Technician	3
Teacher	1
Dance Teacher	1
	115 of 122

Program of occupational therapists. Other categories such as activity workers have even less formal training in this area. From the perspective of potential influence over institutional treatment programs, psychiatric nurses are drastically under-represented as, not unexpectedly, are the psychiatrists.

The large attendance of occupational therapists was affected by the close working relationship that developed between the Music Therapists and the Director of Occupational Therapy at the Health Sciences Centre Hospital. She not only arranged for the first workshop to be an in-hospital, in-service training program, but also worked to involve Occupational Therapists in two other workshops as part of the in-service professional training to Occupational Therapists in other centres provided by the HSCH.

Table 4 lists the institutions in which the participants worked. The range of institutions whose staff attended the workshops is even larger than the range of occupations they represented. The heavy participation from the HSCH reflects the participation of the Director of Occupational Therapy previously mentioned as well as the fact that one of the Music Therapists worked in two different settings within the HSCH.

Table 4. Different Institutions With Staff Attending the Music Therapy Workshop

Health Science Centre Hospital	30 (25%)
Riverview	11 (9%)
Venture	5 (4%)
Community Care Team	
Mt. Pleasant	6 (5%)
Richmond	10 (8%)
Kitsilano	2
South	5 (4%)
West End	1
Greater Vancouver Mental Health Service	3
St. Paul's Out Patients Department	2
Lions Gate Hospital	12 (10%)
Vancouver General Hospital	5
Royal Columbian Hospital	2
Victorian Order of Nurses	3
Children's Hospital	2
Holy Family Hospital	2
Vancouver Neurological Centre	1
REACH	1
Variety Treatment Centre	1
Surrey Memorial Hospital	1
UBC	3
Incentive Crafts	1
St. Vincent's Hospital	1
Burnaby Mental Health Daycare	1
Dept. of Psychology	1
School of Rehabilitation Medicine	1
	113

The other nine participants either did not give an answer to this question or responded that they were unemployed or retired.

Percentages on this table calculated on the basis of 122.

The reasons people gave for taking the Music Therapy workshop broke down into three main areas:

Personal Interest	38%
Further Education	22%
Job Related	37%
Other	3%

There were 144 replies to this question with 22 people giving more than one reason. The most common combination was personal interest and job related. Many who answered the question qualified their job related responses by indicating personal interest. The major way people found out about the workshop was through personal recommendations, the majority of these taking place in the workplace. Twenty-three percent learnt of the workshop through supervisors or employers in their place of work, 22% from bulletins that were either posted at or mailed to their workplace, and 46% on the basis of personal recommendations or encouragement from people who had taken the course or were about to take the course. Nine percent of the participants found out about the workshops through personal contact with the therapists.

The development of the workshops, then, took place through the support of key people in a variety of institutions, and, from that point, word-of-mouth and mailings to specific groups of potentially interested therapists. Support for the workshops and dissemination of the ideas occurred within a natural communications network. This had the effect of promoting wide-spread interest within the institutions, but because the number of formal and informal networks that were tapped was limited, the range of occupational areas within the mental health field was also limited. This is particularly noticeable in the large number of occupational therapists (41), but the small number of psychiatric nurses (2), although there is evidence that the occupational therapists are involving other professional areas.

Table 5 outlines the response to the question, "Did you know anyone else who has taken the course?".

Table 5.

Response	Workshop #1	Workshop #2	Workshop #3	Workshop #4	Workshop #5	Total
Yes	0	7	3	15	14	39 (32%)
No	19	17	12	19	9	76 (62%)
N/A		1		1	2	4 (3%)
D.K.					3	3 (2%)
Total						122 (99%)

As Table 5 indicates, overall, 62% of those who took music therapy did not know anyone else who had taken it while 32% did. None of the participants in the first workshops had contact with anyone who had previously taken music therapy. However, in the later sessions there were large numbers of people who had previously known someone who had taken music therapy. This is an indication of the degree to which the network of communication established to publicize music therapy was self-contained.

Of those who took the course, 28 (23%) said they were encouraged to take the course for professional reasons, mainly in terms of improving their skills or taking training with their co-workers. Eighty-eight (72%) said that they were not encouraged to take the course for career reasons.

Table 6 gives a breakdown of what the participants hoped to get from music therapy.

Table 6.

What do you hope to get from music therapy?

Personal Development and Awareness	20 (18.5%)
Experience in Working with Groups	5 (4.6%)
Better Understanding of Music Therapy	19 (17.5%)
Better Understanding of Music in Work	58 (53.7%)
New Ideas and Information	6 (5.5%)
	108 (99.8%)

The response to this question is somewhat different to the response in other areas. The participants when they started the course were oriented to getting some experience that would have direct application in their work. Personal development accounted for only 18% of the reasons given for taking the course and getting new ideas received only 5%. Better understanding of music therapy which included a more abstract general introduction to Music Therapy accounted for only 17% of the responses. On the other hand, the largest response indicated a very practical orientation to using music in their on-going work. For the majority of participants then, attending the music therapy course was not a desire to discover a new treatment philosophy or to develop new ideas but more the desire to acquire some specific understanding of the potential use of music in their work.

While most people were pleased with the workshop, the evaluations indicated that not enough of the workshop was directed towards the initial practical questions that prompted their attendance. A common complaint was that more time in the workshop should have been directed toward demonstrating the practical application of music therapy.

Forty-one (35%) of those who answered the question concerning the importance of taking music therapy for their career indicated that it was important for their career; 55 (47%) said that it was not. Later answers indicate that the importance to their career is not direct. Attendance is not considered in career promotion; rather the additional therapeutic skills gained are seen as an asset to their careers. This is spelled out in more detail in response to the question asking how participants would use music therapy on their job. Eighty-six people or 70% of those answering indicated that they knew how they were going to use music therapy on their job, while 33 (27%) said that they had no idea. The list of the ways that they anticipated using music therapy is interesting especially when compared to the ways that it has actually been used.

The participants were more evently split between those who knew how they were going to use the results of the music therapy workshops in their personal lives and those who didn't, 47 (39%) and 50 (42%) respectively. The most common replies for the personal use of music therapy included:

Personal Growth	2
Relaxation	5 (11%)
Self-Expression	11 (23%)
Body Awareness	4
Freedom of Movement	2
Lose Inhibitions	5 (11%)

Preserve mental health	2
Music Appreciation	11 (25%)
Play with my children	3
Entertain Husband	
Understand friends	
	47

Previous background in music was investigated both to see the extent to which those who involved themselves in the workshops had a previous musical background and to see whether or not this affected their participation in the workshops as reflected in the drop-out rate. Forty-seven (39%) of those attending the music therapy workshops had a formal background in music; 69 (57%) did not. Formal background included lessons in musical instruments (most often the piano), singing lessons, and dancing. Sixty-two (51%) of those attending the music therapy workshops had an informal background in music while 54 (44%) did not. An informal background in music referred to active hobbies or interests that included music such as folk singing, playing the guitar, choirs, amateur opera or anything else which indicated an interest in music without requiring any formal training. Without having any figures for the population as a whole, it seems safe to assume that the percentage of people who had either a formal or informal background in music is higher than the average in the population as a whole and higher than the population from which they are drawn.

As already indicated, previous musical background seemed to make no difference to the drop-out rate from the course or judging from the diaries, to the amount of anxiety experienced, although it had been anticipated that those with a background in music would be more likely to remain in the workshop than those without.

A final indicator of the degree of previous involvement in music is the extent to which the participants had used music in their job. Thirty-seven (31%) said that they were presently using music on their job, 73 (61%) said they were not.

An important part of the music therapy workshops was the introduction to the participants of a range of music therapy techniques. These techniques ranged from warm-up exercises to more challenging and threatening exercises which demanded considerable personal involvement. Appendix A of this section includes an outline and explanation of the exercises used in each session. Table 7 below gives a summary of the assessment of the various activities in the workshops by the participants. The assessment was filled out immediately after the last session and asked participants to identify the most comfortable (C) and threatening (T) activities for them, as well as the most significant (S) and the most uneventful (U). Finally, participants were asked to identify the activities that they would be most likely to use in their work (✓). No list of activities was provided with the questionnaire which necessitated participants recalling those events. Respondents were able to list as many activities as they wanted under each of the categories so the totals in each column are not restricted to 122 nor are they equal.

As Table 7 indicates, there is a great range among the activities in each of the categories (C, T, S, U). Twenty (16%) was selected in a somewhat arbitrary fashion to be the break point in each area. On that basis, sculpturing, mirroring, dancing to spontaneous music, painting were

Table 7.

	✓	C	T	S	U
Session 1	2	3	-	2	1
2	2	1	-	2	-
3	-	-	-	-	-
4	-	-	1	1	-
Sculpturing	16	21	3	8	9
- body	7	11	7	8	3
- group	8	6	3	11	5
Chanting	18	15	7	18	5
Touching	5	11	2	12	-
Mirror	24	25	10	22	-
Silhouette	14	9	29	19	3
Warm up	14	14	2	6	15
Poetry	19	14	13	24	2
Spont. Music	22	23	6	7	13
Dancing	-	4	2	-	-
- improvised	10	8	3	9	5
- circle	11	7	1	8	7
- rope	11	12	17	21	4
- shadow	3	2	4	2	1
- hop step	5	6	-	1	3
Painting	29	25	6	15	8
Focal Pt.	-	-	16	1	-
Move. to Music	20	9	1	1	2
Reflections	6	4	4	10	1
Write journals	-	-	1	2	1
Vocalization	-	2	1	1	1
Listen-to-music	-	1	-	-	-
	246	233	139	211	76

all viewed as comfortable activities. Silhouetting was the only activity seen as threatening but 29 (24%), the largest number in any category except for sculpting, viewed it as threatening. Three activities were seen to be especially significant - mirroring, poetry, and shadow dancing. No activities received higher than thirteen responses (dancing to spontaneous music) in the uneventful category. It is worth noting that three of the four activities (mirroring, spontaneous music and painting) that the participants rate as being comfortable are also selected as three of the four activities that they would try on their job.

These activities (with movement to music making up the fourth) are selected over 20 times as activities the participants would try on their jobs. Generally, activities with which the participants felt comfortable are most likely to be used on their job. There are only three exceptions to this tendency: the silhouette, which is the most threatening activity, also would be used by fourteen people; the rope dance, which was seen to be threatening by 17 people, would be used by 11; and poetry, which threatened 13 people, was mentioned 19 times as an activity that would be used.

Some activities obviously had great impact on the participants, the two most dramatic emotional reactions being finding an activity either threatening or significant. By adding these two scores we find that silhouetting (47), rope dancing (38), poetry (37), and mirroring (32) all had very high scores. The first two especially had high scores in both the significant and threatening categories.

The decision to use an activity on their job seems to depend on two factors: ease of use and familiarity (movement to music was specifically noted very little in any category, and yet received over twenty mentions; it is also one of the most common activities presently used in the institutions); the comfort or significance of the activity (mirroring was seen to be both highly comfortable and highly significant; painting was highly comfortable and somewhat significant; poetry had fourteen mentions as comfortable and twenty-four as significant).

With the exception of mirroring, the activities that were listed most often as ones to be used on the job were those which were already being used the most often by those who were using music on their job before they attended the workshops. Special mention must be made of sculpting as an activity. There were essentially two different types of sculpting that were done, body sculpting involving two different people, and group sculpting. As can be seen from Table 7, some people just mentioned sculpturing as an activity without distinguishing between the two. Others specifically mentioned one or the other. Altogether sculpturing received mention 38 times as comfortable, 13 times as threatening, 27 times as significant and 17 times as uneventful. Although it is not possible to break down the information any further, it is clear that sculpturing was an important activity and 31 people said that they would use it in their work.

Personal Growth vs. Professional Training

It was expected that there would be some tension existing between the use of the Music Therapy workshops for professional training and using it for personal growth. The earliest workshops indicated that many people were viewing their experiences in personal rather than professional terms. There was also some uneasiness among participants about the relationship between enjoying the sessions personally and how to make use of these experiences in their jobs. It was for this reason that a series of questions were put on the evaluation questionnaire relating to their perception of their experiences both personally and professionally.

The workshops themselves were organized in such a fashion that individuals within each group could shift the emphasis to personal growth or to professional development. Different workshops placed emphasis on the two differently. It is clear, however, from the comments on the questionnaires that for a substantial number of people who attended the workshops, there was an important personal result. This result, although not specifically planned for, on reflection made sense.

One of the impressions of the two music therapists was that many of the therapists attending the workshops were themselves very rigid with little ability to be spontaneous or creative. This was particularly evident in the advanced seminar, where many of the students wanted more structure and were at a loss when the development of the program was left up to them.

Discussing this question with some of the people who had taken the course showed that most of these people are so involved in providing services and leading various kinds of groups themselves that they give little time or thought to their own personal support and growth. Their rigidity is not a result of personal characteristics but is the result of the structural demands placed on them in their work situation. The heavy work-loads, combined with the lack of personal training, result in people oriented to achieving a routine as efficiently as possible with little thought given to the development of new forms of therapy or to the limitations of existing programs.

What training is provided is academic by nature. Training sessions present and discuss new forms of treatment or new ideas in their professional area, but there is no active participation by the workers. With the exception of psychiatrists who must take part in psychotherapy, none of the other workers have had personal involvement with therapy programmes unless they have taken it on their own time either through need or interest.

The main emphasis in existing therapies in the various institutions from which the workers came was verbal. This is true for the psychiatrists who do individual therapy as well as most of the various group therapies run either by psychiatrists or other professionals. Apart from the therapists, another important segment is the occupational and recreational therapists who,while not engaging in verbal therapy, are looked on as adjuncts to the therapeutic process and not central to it.

The result is an orientation to therapy which heavily stresses verbalization, and therefore the intellectualization of the emotional or problematic aspects of their lives. The verbal approach makes it possible to deal with problems at the rational level without dealing with feelings directly. It is then possible to deal with your own problems as well as encourage others to deal with their problems within the relatively safe confines of the spoken word. Although this does not discount the possibility of breakthroughs occurring at the verbal level, the stress is clearly on one way of dealing with problems. The encouragement of verbal therapy as the almost exclusive treatment modality in many centres is closely connected to administrative priorities for patient and ward stability.

The music therapy workshops for the various treatment professionals were difficult for two reasons. First, they introduced a non-verbal treatment orientation. Secondly, the workshops were not lecture oriented but experiential. The treatment workers not only learned about the therapy, but were involved personally and experienced the various techniques.

This personal involvement was important for many of the workers, who were personally involved for the first time. Many talked about the importance of the sessions to them personally. A number commented in their diaries that they were tense and wound-up when they came to the sessions but they were able to relax and unwind as a result of the workshop. Some of those who attended the morning workshop commented that they had new energy and related to their patients differently.

At one level then, the question of personal growth and professional application are synthesized. The personal experience with the music for some of the workers resulted (according to them) in their being more relaxed, sympathetic and understanding, better able to function on the job. One function of the workshops became a therapeutic centre for the workers themselves. This was more effective because it was a new treatment modality and a non-verbal one. The various defenses people develop at the verbal level are less effective with a non-verbal therapy. The workshops uncovered a tremendous weakness in our mental health care system in terms of the strengthening and support of the workers themselves.

These findings and analysis support the organization of the workshops. The understanding of a therapy and its consequences is far more powerful if the workers have some first-hand understanding of the therapy. This, of course, has consequences beyond these workshops, but points to one reason for their success among one group of participants.

At the level of professional training to be used in the various institutional settings from which the workers came, the workshops were more of an introduction to music therapy than an actual training session. It was found that the majority of the participants did not feel that they had sufficient training to use music therapy or felt the need for on-going assistance in introducing music programmes. The Music Therapists felt, and this tends to be supported by the results of the questionnaires, that many of the participants simply did not have sufficient grounding either in music or in the theoretical aspects of doing therapy. This made the experiences in the workshops hard to integrate. Superficial examination of those who seem to be making the best use of their training indicates either a very sound theoretical basis to their work, or a strong experiential basis either in music or their personal experience relating to working with people or understanding themselves. They were, in other words, exceptional therapists to begin with.

A number of the people who took the music therapy workshops felt that they would not be able to use music therapy in their present roles, but would like to do so if an opportunity presented itself in the future. Many others that we talked to or who filled out the follow-up questionnaire indicated that they were using music more actively in the existing programmes than they had been, or they had integrated various elements of the music therapy training into their own on-going programmes. Although this did not mean the development of separate music therapy programmes, it did mean that techniques of music therapy were becoming an important element (or as many put it - "another tool available to the therapists") in existing programmes.

The workshops acted to sensitize people to the value of music therapy more than it served to get formal music therapy into the various institutions. Not only are the people who took the workshops more aware of the potentialities of music therapy but they are taking this back to their various institutions. Through their use of some of the techniques, combined with their discussion of the workshops and their personal experiences, they are sensitizing a far wider group within the psychiatric community. As a selling job, these workshops, combined with other conferences and meetings, have served to introduce many people to the potentialities of music therapy. This has not happened through empirical support for music therapy, but as the result of people's personal contact with the workshops, or through direct contact with the work in the various institutions where music therapy was used.

The goal of the workshops to train people to use music therapy was too grandiose. It was dependent on the participants having a very high level of understanding of both music and therapy. It is now clear that the workshops served a useful introduction but on-going training is necessary for even a modest understanding and use of music in existing treatment programmes, and a much longer and more intensive course is required for people to be properly qualified to do Music Therapy.

One of the results of the increasing interest in Music Therapy, mainly generated by this demonstration project, is the development of a two year course in Music Therapy at one of the local colleges. This will be discussed later.

For those people who are using some of the elements of music therapy, there were a number of requests that the workshops include more practical elements of using the various techniques in their particular situation. This included discussion on the use of video-tapes with specific kinds of patients. People also wanted more information on the choice of music and where instruments and supplies could be purchased. Given the two-fold nature of the introductory groups, it is probably necessary that this be part of a follow-up group that is oriented to much more practical activities, and to working out specific problems people are having in using the techniques in their work situation.

One of the interesting questions about the structuring of the Music Therapy group was the timing of the sessions. The location of the Music Therapy session in the daily routine of the participants was seen to be a major factor by some of the participants as well as the two Music Therapists. The afternoon sessions were viewed as the least desireable time as many of the people had to work right up until the time it took to travel to the session. This meant that many were tense and exhausted at the end of a long day, and it required some time before they were able to become involved in the session. They were often too exhausted to get maximum benefit for the sessions. The evening had some of the limitations of the afternoon sessions but people had a time to relax after the day and to enter the sessions somewhat refreshed. The morning sessions (which the two Music Therapists felt were the best) had the advantage of people just beginning the day and being refreshed. The morning sessions also had the further benefit that the effect of the Music Therapy sessions lasted all day long and had an impact on the quality of people's work during the day.

Participants' Evaluation of Music Therapy Workshops

There were two questionnaires used to get participants to evaluate the workshops. The first questionnaire was given immediately after the last session and the follow-up questionnaire was given two to three months later. The purpose of the final follow-up questionnaire was to find out how extensively people were using the material from the music therapy workshop.

Ninety-four (77%) of the post-workshop questionnaires were completed while only a disappointing 55 (42%) of the follow-up questionnaires were completed, even after two letters and a phone call to each of the participants. While the post-workshop questionnaires give a reliable overview, this is less clear with the follow-up questionnaire.

Post-Workshop Questionnaire

While 13% of the participants had no specific suggestions to make, the post-questionnaires revealed a number of recommendations for changes in the structure of the workshops. The most common suggestion, made by 25% of those who answered the question, was allowing more time for discussion of the material in the workshops. The next most common suggestion was to allow time for the diaries to be completed at the end of the session. Many of the participants complained that there was little time to get to know other people in the workshop and more time should be spent developing a feeling of "collectiveness". Another common recommendation was for more material and time to be directed to specific groups of patients. The second workshop in particular, composed mainly of Occupational Therapists, desired more specific information on application.

From a personal point-of-view, the participants felt the main contribution the workshop made to them was an increased appreciation of music (25%), increased insight and personal awareness (25%), and a technique to help them relax (14%). Other areas that were frequently mentioned were increased self-confidence, less inhibition and greater understanding of others' responses. Ten percent of those who filled out the questionnaire felt that they gained nothing personally.

When asked how they planned to use the course material personally, the answers followed a similar pattern except that 14% indicated that they did not plan to use it personally, and another 13% said they didn't know how they would use it. The largest number, 27 (29%), said they planned to use the course material for increased music appreciation; 17 (18%) said they would use it to aid in self-expression.

In response to the question about how the workshops contributed to their professional growth, 32 (34%) indicated that it provided them with a new therapy technique, 15% said that it gave them a better understanding of groups, 10% said that they had gained greater confidence in working with groups, and 7% said that they had a better understanding of the value of non-verbal communication. When asked how they planned to use the course material on their job, 33 (35%) indicated that they intended to use it with groups. However, a better understanding of the range of ideas the answers appear to be very vague, such as working with groups. These answers, combined with the discussion of the specific activities that they are planning to use, indicate a not unexpected superficiality in their understanding of music therapy which is partly recognized in the numerous comments about lacking confidence in its use. This discomfort is also displayed in the already stated desire of many of the participants to have more discussion time and more information related to specific uses. Some mentioned the possibility of having videotaping of actual use of music therapy with different client groups.

Follow-Up Questionnaires

The three month follow-up survey was oriented to finding the extent of participants' use of music therapy on the job. Of the 51 replies, three said the question was not applicable, 20 (39%) said they were not using any of the techniques, and 28 (55%) said they were using them. Table 8 shows the breakdown of the reasons given by those who are not using Music Therapy techniques.

Table 8. Reasons For Not Using Music Therapy Activites on the Job

No Answer	2
*Not working with patients or groups on my job, not necessary on job	7
Too Lazy	1
Not appropriate for my patients	1
Don't have resources	2
**No opportunity	6
Not confident enough	1
Total	20

*Means not working with patients or groups, with psychological patients or not a part of present job requirements.

**Means not yet having permission, staff rotation requirements.

Table 9. Reasons for Using Training

No Answer	12
Good for relaxation	2
Strengthening vocal range	1
Good for my patients	5
Exercises	2
Self-expression	2
Non-verbal expression	1
To encourage enthusiasm and joy	2
Part of my job	1
Total	28

Table 10. How Are You Using the Music Therapy Techniques in Your Job?

No Answer	1
Movement to Music	5
Exercise warm-up	3
Relax group before therapy	3
Using several techniques (mirroring and body sculpture)	5
Singing or verbalizing	2
With patient groups	6
With individual patients	1
Instruments	1
Total	27

Of those who are using music therapy techniques in their jobs, 16 (57%) were using music on their job before taking music therapy, 11 (39%) had not previously used music therapy.

When asked if they had any difficulties using music therapy on their job, 17 said there had been no problems, 12 said that they were not using it, and eight mentioned resource problems such as time, space, noise, equipment and technical problems. A further eight mentioned difficulties with their particular patients such as: getting elderly patients to participate when they are not anxious to try anything new; the limited span of attention of some patients and the difficulty of keeping them involved; some are threatened and won't co-operate which makes it uncomfortable for the group; the difficulty of establishing a constant group because of the inconsistency of patients in an acute setting; and the occasional complexity of instructions. Four people didn't answer the question and two mentioned staff skepticism. Apart from the 12 for whom the question was inapplicable and the four who did not answer the question the therapists found music therapy useful as a new technique (8), as a universal language (4), as a way of loosening inhibitions, giving self-confidence, and relaxing (7). It was seen to be good for non-verbal communication (3), because patients enjoy it and respond to it (2), because it has led to discussion among patients (2), and because it has been good with handicapped patients (1). Three did not find it useful, one didn't know, and one simply responded that it had been useful.

When answering the question about how their patients responded, 14 said mostly with enjoyment, six said positively, two said they were hesitant, and two said that the patients themselves had organized additional sessions. Seventeen people said the question was not applicable, four did not answer, four said the reaction was varied, and one said that it was too early to tell.

When asked about how their co-workers felt about the music therapy, 18 said mostly positive, five said they used it too, or wanted to, three said there was a varied reaction, two were interested but doubted its practicability, and four were either uninterested or opposed to it. Six people did not answer the question and eight said that it was not applicable. In addition to the fellow workers, music therapy participants were asked how their supervisors felt about them using music therapy. Of the 32 who answered the question, 12 said their supervisors were very positive and encouraged its use, 18 said they seemed interested and approved, one said the reaction varied and one said their supervisor did not think it was very practical.

Although the number of people who responded to the questions is small, the answers indicate a general acceptance by both fellow-workers and supervisors of the use of music therapy. This is borne out by the interviews that were conducted at four of the institutions that had large numbers of staff attend the music therapy workshops.

The three month follow-up questionnaire also asked the participants in the music therapy workshop to assess in retrospect their assessment of the strengths and weaknesses of the workshops in overview. The assessment was very positive. Although people put down weaknesses, it was clear from both their comments on the questionnaire and their diary comments that the sessions had been very enjoyable or important experiences for a large number of the participants. This is probably because of the degree of personal involvement in the workshops.

Although 21 people, when asked how they used music therapy in their personal development, said that they had not so used it, eleven reported making use of it for sub-awareness understanding how music affected them, six said they used it to encourage more spontaneous movement in themselves, four to gain greater confidence with people, and five for relaxation purposes.

Table 11 gives the list of responses with which people assessed the strengths and weaknesses of the music therapy workshops.

Table 11.

Strengths		
No Answer	6	(12%)
Enjoyable and Useful	5	(10%)
Group Participation and Involvement	9	(18%)
Meaningful Communication - Group Feeling	6	(12%)
Relaxing	2	
Low Key	2	
New Use of Music, Valuable	5	(10%)
Many Strengths	1	
Concrete Suggestions for Therapy Activity	1	
Total	51	

Weaknesses	
None	2
No Answer	16
Needed More Time	5
Needed More Discussion	4
Needed to be More Concrete	4
Group Too Large	4
Some Patients Will be Threatened by It	3
Needed More Help Selecting Music	1
Not Quite In-depth Enough	3
Needed More Time to Know Each Other	2
Needed More Theory	2
Needed More Experience Rather Than Teaching	1
Still Feel Uncomfortable with Music Therapy	1
Poor Attendance by Some	1
Questionnaires	2
Haven't Had Chance to Use	1
Total	51

The mere categories listed above give little idea of the comments people made about the strengths of the course. The following verbatim comments give more of a flavour: "well organized and useful"; "very useful tool of group exercise"; "got to know fellow employees and myself better"; "varied-concrete suggestions for getting mileage out of each activity"; "good techniques and presentation"; "leaders have a good attitude"; "very inspirational"; "good to experience the receiving end of therapy"; "good organization and good theory base"; "imaginative enthusiastic leaders".

On the weakness side most of the responses were brief and of a fashion already noted above in Table 10. Only a few deserve elaboration: "possibly too much reliance on subjective interaction"; "some exercises could have been more deeply developed"; and finally, "time was too short and had to rush"; "perhaps too inhibiting for many patients"; "they already have problems with interpersonal relationships"; and the fact that "some of the exercises make them seem childish and ridiculous - may not be good therapy".

In general the follow-up questionnaire has indicated a lower level of use of music therapy than anticipated. This is true for both the extent of use and the depth of use. Previous discussion in this chapter has indicated why this was in fact the case and has suggested that the objectives of introducing music therapy as a complete therapeutic philosophy and tool was too grandiose. A more appropriate objective given the time limitations and the background of the participants was simply to provide a general introduction to music therapy and a sympathetic awareness of its potentialities. This was accomplished.

It is difficult to make any clear-cut comments about the use of music therapy techniques as the result of this survey. The rate of return of the questionnaires was disappointingly small, and therefore the number of people that can be examined in detail is small. However, it appears that the number of people using music therapy in their jobs as a result of the workshops is small. For many who are not using it, it is a result of their job situation (Table 8) and they have the intention of using it later. Many of those who are using Music Therapy now and had used it previously remarked on the usefulness of picking up new techniques. What seems to be clear is that few, if any, are using music therapy in any systematic sense. Although the workshop originally intended to train music therapists, this study has shown, as the instructors themselves perceived, that the depth of therapeutic understanding did not exist as a basis for the integration of music therapy into existing treatment programmes. It has instead been "tacked on" as another technique in the repertoire of the therapist, abstracted from its philosophy and divorced from its methodology. In retrospect, nothing more should have been expected or could have been accomplished. The workshops have had the affect of increasing interest in music therapy (as evidenced by requests for additional workshops and requests for consultations from those who have already taken the course). It has also encouraged an understanding of music therapy at a different level than accomplished by most introductions that depend on the mind and not on the emotional understanding so necessary for the therapist.

Composite Diary

These comments are taken from the various diaries. Although they are representative of the comments made on each activity, they do not give a complete picture. This is because each of the comments is taken out of the context of the complete diary. To follow one diary through would give more of an understanding of how individuals responded throughout the entire session and how various activities reinforced or detracted from their development.

First Session

1. Frame of Mind Before Session:

Before the session I was feeling up-tight and exhausted from a hard day.

I just this afternoon heard of the opportunity to take the workshop and almost didn't come because I was so tired. But I was able to relax and get into the activities much more than I expected and was very glad that I had come....

I had had a rush day - no breathing space during the day - felt keyed up, somewhat apprehensive re my ability to "let go and lose myself". Looking forward to the session....

I was tired but felt like being silly and joking around. I also felt put off by the questionnaire....

Tense and apprehensive - had no idea what to expect as I had never attended anything like this before....

Felt rather apprehensive but also exhilarated....

I did not know what to expect. I hoped the session would be a practical one and I was pleased that it proved to be so. I was also a little dubious of how effective this kind of therapy would be and it was therefore with great interest that I came to the first session....

I was self-conscious and a bit worried that it would be "airy-fairy" and not of use to me as a technique, but hoping at the same time that it would be useful and rewarding....

Feeling positive because of positive feedback from someone who attended the fall session....

I was quite relaxed and in an amiable, peaceful mood before the session. I did experience a slight bit of anxiety on entering the hall but this declined when I recognized a few people....

Tired from work all day, open to anything that was to happen, anticipating a relaxing time, happy about meeting new people, enthusiastic....

I was definitely skeptical about the whole thing, slightly bored, tired from long day's work - thinking I had booked into this months ago and wondering why I had bothered, etc. ....

2. Activities:

Warm-Up

In the warm-up I felt self-conscious and rather silly initially, but as the activity progressed, loosened up and enjoyed the music. As more people joined together the relaxation increased....

...felt stiff walking around the room, my limbs all too aware of themselves as separate entities - having to close my eyes to get into the music...some release of pent-up energy - disliked becoming small after that....

Somehow the "Hallelujah Chorus" was too loud...I was glad no one pointed me out as the leader during reflections. I was unable to dream up any such activities....

In general I liked this exercise but feel it could have been less threatening and more closer if the large group was divided into two or three groups with a leader. Music excellent in releasing various types of energies....

Fun imitating a leader...I found that I was a little bored with the music, it all seemed to be of a similar tempo....

It allowed me to emphathize with several of the others and learn something about how they feel without actually speaking to them ....

Gives confidence to those who feel they couldn't lead in such a way. When you see someone else manage it increases your self-confidence....

I found "follow-the-leader" non-threatening. I could enjoy the music without having to initiate innovative movements. Then I was put "on-the-spot". At first I felt slight panic, then I relaxed somewhat and decided to move as I felt the music move me. After I finished leading I felt pleased that I had 'performed' well,...and had generally succeeded in my short stint as leader. I found that I had been part of a group, then been made leader and then a part again and somehow that made me feel closer to the others....

Physically a bit difficult to try and follow someone's actions, fear that the finger would be pointed at you and you wouldn't be able to think of anything.

Mirrors

Mirrors was fun. I enjoyed following my partner and was surprised at the difficulty in copying the movement. To lead, it was easy just to move with the music....

Liked the slow expressive music, liked my partner, felt comfortable...felt confident I could be creative, felt I could communicate and express my feelings quite adequately....

I was leader first. My bones cracked and I wanted to be graceful but felt stiff. My partner stared at me all the time - a little disconcerting, but when I followed I found I had to do that too ....

I started to feel I was a bit clumsy (I started comparing myself to how I would like to be)....

Gives more direct communication, expands confidence gained from previous activities, interesting to see response from partner....

I began to get a deeper response and more enjoyment and by now I think I was fairly relaxed....

It was a bit more personal and somewhat uncomfortable at first. Music was too repetitious again, I felt. It was easier to lead than to follow although it was difficult trying to think up varied movements....

Enjoyed this exercise in terms of non-verbally communicating with another person and sensing other varied responses to the same music....

Nice to have someone follow my movements....

Felt quite comfortable in this activity but felt the music was uninspiring....

I began to unwind although I was a bit embarrassed to start with. I got over that....

I enjoyed this and felt it helped to loosen me up physically.... I think the music helps me to focus music away from myself and thus I feel less self-conscious and more comfortable....

The warm-up was okay - not as bad as I had anticipated, although when we were asked to find a partner to walk with, this renewed initial feelings of apprehension but felt better as 2-4-8-the whole group....

Knew a lot of people there so kept meeting people's gaze which was distracting and I felt more self-conscious....It was hard to do anything original in case I drew attention to myself....

The warm-up exercise in fact made me very stiff, my movements became awkward and repetitive. I became conscious of each of my moves, I started admiring graceful movements of my colleagues ....Did not take long to notice that each of the participants interpreted the music in their own way...which was a signal to me to do my own thing regardless of what has been going on around me....

This was a non-threatening way to start the session and encourage participants to join in and feel at ease....

Felt a bit self-conscious when walking around at first - began to get into exercise and enjoyed walking large and obnoxious. Felt secure walking tiny, felt more secure as we joined into walking in larger groups....

I enjoyed finding my own space....I had problems with walking uniquely with four persons than with either two or a larger group. It got to be a fun game....

This exercise lowers my tension....

The first warm-up exercise was beautiful...it really helped me to relax and slow down. The warm-up did help to feel more acquainted with the others....

I didn't enjoy it. I didn't like the music and could feel little for it and my feelings were somewhat negative, thinking if the music was to continue like this I would be unable to participate ....

Reflections

In reflections I couldn't quite get in gear with the music, stressful situation....

Was happy not to have been picked to lead. Enjoyed following someone else's lead en masse....

Enjoyed this and felt it helped me to further loosen up. I liked the more active "Hallelujah Chorus" and felt "Brown Baby" went on too long....

I found it difficult to follow but easier when I became the leader - however I still felt my movements were guarded as I was still very tense and cannot honestly say I enjoyed it....

It was a relief to know I could pass on the leadership at any stage. In the slow-flowing music my sense of the ridiculous was amused by us all dancing about trying to be like ballerinas....

I felt silly but despite this noticed my tension disappearing as I had to concentrate in order to "copy" my partner....

Touching

Not as difficult as I thought it would be - was very apprehensive that I would find it distasteful - however my partner and I seemed to get into some sort of wave length and we danced without either of us leading....

This was really beautiful - both the leading and being led and as suggested, it often happen that we just flowed with no apparent leader....

I preferred the touching with eyes closed exercise as I felt less inhibited when I could see no one and no one could see me.

Good....

..Liked the heightened sensation of feelings another's emotions without having to speak about it or see it....Liked having the opportunity to speak with partner a minute about the experience....

This was very difficult for me as I felt very inhibited. My movements were not as easy and flowing.

Felt really good...felt close to that person; amazed how tuned in to each other two relative strangers could get so quickly and with so few cues or props.

...It was easy to keep eyes closed as I was totally involved in the feelings and sensations going on. Good for awareness of another person and team-work developing. I knew my partner a little but would have felt much more inhibited in touching a stranger (especially a male, I think) (writer is female).

Touching was not a pleasant experience for me and I must admit I peeked from time to time. I would not like to do that exercise again....

A nice follow-up to mirrors. I felt it was more personal and I liked that and the closer contact. However again, I would have preferred some variation in the mood of the music....

Very tense and sweaty - not a common every-day thing to do....A combination of some discomfort to me and some very enjoyable flowing movements....

Much the same as reflections but more personal, more intense....

Sculpturing

I enjoyed sculpturing more than the other activities because I was working with a group....

I didn't enjoy the sculpturing much, either in the small groups or the large one. I didn't like having to hold still in an uncomfortable position for more than a few seconds....

To see the way a person can become an integral part of a group - to share, to lead in a movement, to allow another to lead, to be swept along with it, to discover again one's ability to tolerate physical closeness. To be part of a creative effort where each part is important in making the whole a good thing....

Feeling a bit silly - feet and heads poking through space - not too graceful when one has to keep contact with both hands.... Debussy another favourite - my mind into the music if not my body ....

This was fun, being part of a group working together.

I liked it but felt it went on a bit too long.

I did not find sculpturing as threatening - probably because it involved more than one other person and I felt it to be a team effort so to speak.

...Interesting, plenty of room for imagination and experimentation ....

Liked security of small group when moving but staying connected....

This was very enjoyable. The sculpturess placed us in an interesting form and we were able to relate and communicate for our movement. There seemed to be a real flow.

This I really enjoyed, good contact, verbal, body, and movement. Besides an aesthetic touch from the positioning and it was interesting to see how we moved in unison and retained our "initial" sculpture.

Found this most enjoyable - a fun activity which brought back a group feeling as the first session came to a close. Gave opportunity to lead others and interpret feelings and mood of each individual.

The most difficult part of this in our group was deciding who would be the sculptor....Moving our sculpture was difficult and the time seemed so long - yet when we finished it felt so good - especially when we received some recognition from the group.

I chose a very simple smooth shape - we had a great time moving within our group - very spontaneous and lots of fun. Liked the people in my group.

Group Sculpturing

...I was surprised to see in the group sculpture that the sculptor on choosing bodies held the person's hands, a rather unique situation.

Didn't like being the last person to be placed but sculptor very gracious in adding me. Once again most fun when everyone moving rather than static. Feeling that have had enough - glad that discussion began to change the pace from activity.

...Brought back feeling of belonging to group as a whole. Most enjoyable.

I didn't feel as involved or related to this activity as I did to the previous one. It seemed too big and disjointed for me to relate to it. I was more observer than participant.

Again I felt relaxed in this non-threatening group.

The group sculpture really became kind of fun.

I had fun but was less aware of the music....

I was able to reach out to others and feel part of a total happening....

A lot of waiting in a tense position - didn't get too much out of it. Interesting idea for getting a lot of people in close contact in a rather subtle way.

3. Application for Use With Your Clients:

At present with my elderly general exercise class this would be of little help to me as I want a great deal of bounce and fun.

I do not feel that I learnt anything that will help me in my work - as I am a domicilary physio-therapist - dealing with physical and social problems in the home - majority over 60's.

I expect to use these exercises with education students because already I can feel the positive results.

Warm-up exercises and reflections, sculpturing could be used with our patients (chronic psychiatric problems) - mirroring would be too threatening for them at this point....

No idea yet how to use music with hyperactive kids in my group - want to talk to Nancy about it after I see total sessions.

Many of the individuals I work with are in wheelchairs. I tried the mirroring and the touching with one group of patients, mostly hemiplegics....I found they enjoyed it, it helped to increase awareness of the affected side, and it gave information of the individuals' movement patterns to the therapist.

Limited in my particular area of physical treatment....

In my work at ____________ I run several activity groups - one of which is a physical activity group....I really think that the addition of music will allow much more self-expression and I plan on trying these exercises - followed by verbal discussion if necessary.

My type of client would not be able to use this activity...as they are limited by physical handicaps.

I am presently involved in a music therapy group in my job (psychiatric nurse), and have been working with someone who has already taken this course. With this workshop, I feel more equipped and confident in working in this capacity, which I find an exciting approach to communication.

Mirroring and reflections could be used with our patients who are physically or mentally disabled and in wheelchairs. It would keep them in reality and in contact with others.

Could use it in a group of 9-12 year old overweight children who are in a group to encourage them to move and take more exercise.

I feel that I could make greater use of music to enhance the exercise groups I run.

I work mostly with cerebal palsy and mentally retarded children. Mirroring is the best one I could use in body integration.

4. Summary

Altogether, I really enjoyed the evening - felt pleasantly refreshed and stimulated.

It was a good session, very enjoyable, by the end I felt quite exhilarated and looking forward to the next week.

However, if I had anything on my mind when I first arrived, it was all gone by now. It was an engrossing experience and though tired and thirsty I was relaxed.

The over-all feeling of the evening was of release and fulfillment. A good feeling of well-being existed plus a stimulated mind resulting from an interesting evening.

Second Session

1. Frame of Mind Before Session

I came to our second music therapy session feeling relaxed and looking forward to the evening. Having been working for several years, it is a real joy to be in a situation where you feel like a student again and are learning something interesting and enjoyable but also have the benefit of working and independence.

I approached the second session with quiet anticipation. I had good feelings about the course from the previous session.

I was feeling quite positive on arrival but when told to go and find "my place" I felt, uh, not this again. But somehow once I went and did it I felt better.

Looking forward to session...that we would be using some musical instruments created more interest.

This time before going to the session, I was looking forward to it, hoping to learn something from it that I could bring into my treatment of patients.

2. Activities in the Session

Warm-up

The warm-up drum music was okay but I didn't have the same kind of enthusiastic response as I'd had to the first activity the previous week.

Warm-up allowed me to forget what had gone before in the day and I responded here and now to the drum beat, a great way to project feelings and express mood by identifying with the beat and pick up one's own beat.

A terrific start to the evening, it was so totally different to what I had been doing all day - it helped clear my head from all previous thoughts.

An easy-going, light introduction exercise. I liked the idea of being able to loosen up in one's own space and energy as an opening exercise. Music had a nice build-up for energy.

Found it very exciting, thoroughly enjoyed the drum music, gave opportunity for experimenting within boundaries....

Drum music great to jump about and move with large movements.

Warm-up exercise was fine, it made me feel in the mood for the session. I knew what to expect as it was similar to the warm-up exercise the week before.

Make a Circle With the Rope Around You

Joyish, childish feelings like ring around the rosy. I liked jumping around like a war dance, not having to be graceful - did not sense aggressive feelings but just vigorous ones - being aware of my body energy for the first time that day....

This was exciting for it was filled with unexpected happenings. One minute one could feel in control, the next moment be completely out of control and responding involuntarily to someone else.

The rope dance excited me although I found I really had a strong urge to lead, and felt my aggression taking over.

This was a rough disjointed jerky activity which jolted me out of my relaxed mood. Had I had feelings of anger or frustration, this activity would have done more for me in expressing myself in an appropriate way.

I found there was a chance to lead and be led. It gave me a very free feeling - freedom to choose whether to be aggressive or passive.

I really enjoyed this exercise, was able to release a lot of energy, become involved in a growth exercise as a group.

It was a happy exciting release to be tossed around against my will but safe inside the rope. I felt as though I could completely let go and be controlled by others for a change.

Rope with Smaller Groups

Really liked that because the movements were even stronger, felt energy surging that I wanted to use and use fully. Felt myself wanting to toss others.

It was great, really good experience, just the two of us, moving with the music and then we began to mirror each other. We were one, and it was good to be able to do something with the music. When we sat down, those around us agreed that it had been a good experience just watching.

I liked having a chance to use the rope again because I still had some energy left. I like the idea of allowing those who felt uncomfortable to have their own dance so that the experience became a positive one.

Silhouetting, Individual

A loose experiment for me, wanted to do it longer but felt a time pressure.

This was beautiful to watch and real rough to do - I definitely felt up front and on stage. I couldn't just lose myself as I'd wanted to. I felt too conspicuous.

I didn't like it at all, in fact I hated it. Instead of enjoying it and learning from it, I'm afraid I just closed up and miserably waited to get through the whole thing. I would not use this exercise with the patients I treat.

Silhouetting alone was quite threatening for me. I don't enjoy being in front of a large group. I felt clumsy and awkward and out of rhythm. I was too self-conscious to let the music work on me.

Enjoyed this most of all activities. It provided opportunities for individual and group experimentation with music and shadows.

Was a great idea. Can't wait to do it with my patients.

Silhouetting, Group

Felt creative, had a quick idea and arranged the group. Felt like a leader, which isn't the usual me.

Having someone else there definitely increased my comfort level.

Enjoyed this but would have liked more than a 60 second preparation time. Groups behind the screen would have been more effective because the viewers would have been watching the shadows rather than the individuals.

I found our group effort very satisfying and really got involved in the actions and the relating with other members of the group. I found I forgot myself and felt vigorous, amused and really turned on by the whole exercise.

My group was somewhat negative to begin with but we became engrossed in ourselves and we all felt let down when our music completed before we had finished our plan.

The group silhouette was not the greatest. I felt that each one of us had such varied ideas that a compromise would have taken more time than we had.

However, in a group doing silhouette sculptures, I became mesmerized by the graceful movements on the screen. I enjoyed experimenting with actions, and enjoyed the challenge of co-ordinating my actions with other members of the group.

Felt frustrated during it. We hadn't followed through with our original plan. The group seemed to fall apart for me and not come together....exercise in frustration.

Improvisational Dance with Extensions

By now I felt loose and relaxed and ready to be taken by the music, so as a result I did and I found this exercise the most therapeutic for me. I consequently found it one of the most beneficial experiences of the evening. It helped me to appreciate how much the music could affect me and did.

Thought I found my instrument, but found it wasn't. Might have enjoyed it more with specific accompaniment. Found the cacophany of sound rather musical.

I found it a bit confusing, both the direction to extend the gesture until very large and you moving around the room with it, and the accompaniment by a musical instrument. Just didn't seem to flow well.

Liked accompaniment of instruments and would have liked a chance to explore some of the instruments before using them. Basically found the exercise a creative one.

After the other activities which required overall more energy and movement, I found my participation in the dance section of this rather slow and boring. Didn't gain much personally compared to the other groups.

Find Your Spot Again

This was a good last exercise. It continued the atmosphere of concentration. I found it very calming to find one small movement and sound....

A terrific end to the evening. Found the combined sounds beautiful - it was like losing the boundaries of the self to find the universal self.

I was glad of this break to be alone, an activity to make one so aware of self and the sound of self....

Found this very effective in finding the contrasts between sound and movement and then complete quiet. At the end, this exercise tended to relax me to the point that I was too tired to participate fully in the questional and answer period following.

I experienced a feeling of peace and calmness, a sort of pulling everything together inside into a sort of wholeness....

Very relaxing - a beautiful end to a session which generally required more physical activity than the first. Could have been longer but I suppose I would have gone to sleep then....

(This last is from somebody who left the course at this point:) I feel I should say that one of the basic reasons I disliked the class is that I generally like to communicate with people through speech and therefore feel quite lonely, awkward and alien dancing around with a group of strangers.

3. Application:

The warm-ups,silhouetting and improvising would be applicable for the handicapped children I work with, who are restricted in their movements and who don't get to experience music and movement to it as often as non-handicapped children. I see it as an extra medium for stimulation and expression. Also as a means of gaining rhythm in certain specific movements where they often have difficulty attaining this. The rope dance, improvisational, and especially the quiet spot I would like to use with hyperactive and behaviour problem children.

The warm-up, rope circle and rope with small groups could be used with creative expression or communication groups. I probably would not use improvisation dance with extension as I don't have the instruments, and I think the silhouetting would be too threatening ....

With some planning I would be able to introduce some aspect of music therapy, mainly in the form of using soothing music when inhibiting spasticity.

Excellent for increasing co-operation and awareness of others.

Found especially the rope dance exercise and the silhouette exciting exercises to present to a group for increasing awareness and providing a valuable learning experience....

Cannot see myself using these particular activities with my physical patients except for quiet spot.

The only one of these exercises that I can imagine using with my kids is the individual silhouetting to improve body awareness, but I found it the most uncomfortable for myself.

May try the silhouette with kids - will help their need to be the 'boss' and be 'big'.

Session Three

1. Frame of Mind Before Session

No one seemed, for some reason, to include these comments in their diaries on this session.

2. Activities:

Spontaneous Music

Itfelt mildly frustrating when we were playing, the group as a whole, and we couldn't seem to make music, that is, it rarely sounded other than a jangle of noise...it was more meaningful to me when we had decided into groups and the rest of the group listened as each kind of instrument was played.

It was interesting to see what sounds could be produced but I felt it was largely discord...listened to smaller group playing was easier to the ears and somewhat interestingly sitmulated the imagination ...in general, I felt the sound (noise) quickly became monotonous, especially the drums, which were simply banged with little feeling of rhythm or pulse.

It was so good to feel the freedom of unstructured music, unbound by the conventional structures and discipline. I really got in touch with some of my aggression during this time, and for the first little while really wanted to hammer on the drums.

Playing instruments at random gave a good chance to settle down and feel at ease with the group...as a participant in the drum group I can't say objectively what we sounded like, but I got a big thrill from realizing that whenever I played the big drum loudly, everyone else in the group responded by playing loudly too....It was very gratifying and gave a sense of power and control over the group. It would be very therapeutic for the shy retiring person to feel how rewarding it can be to assert one's aggressive side at times.

In comparison to other activities we have experienced, I found this the least involving for me.

I really enjoyed trying all kinds of instruments, it was nice to not worry about playing them properly....I chose the banjo to play in the small group first....I switched to a small instrument with metal bars to be plucked with fingers in the large group. I found the instrument very unsatisfying and thus boring. I felt like I really wasn't participating because I couldn't identify with the tiny plinking sound.

In general I found this activity very scattered and anxiety provoking....The part that I did enjoy was when the instruments were divided into three groups, strings, wind instruments and drums. I felt that as a group we were able to listen to one another and find a common mood message rather than being on our own individual haphazard paths.

I enjoyed the sounds of our group, soft and we were all able to hear each other. I enjoyed listening to the string group and forming images. I found the percussion group frustrating to listen to. Seemed to be a loud din and with change and little melody. It did conjure up definite images of violence, evil and power, but I did not enjoy these feelings and I wanted peaceful, contented feelings. I also did not enjoy the whole group playing. The percussion group seemed to take over. I felt frustrated that I was being overpowered, except for a few minutes.

I became aware of the various moods each instrument could express, and of how some instruments lend themselves to various feelings.

Chanting

I really got into the chanting and I thought it was a great idea just to see what would flow from me. It surprised me how easily I was able to feel like a child in the 'kid's playing together' chant.

Om chant - a glorious moving feeling. War chant was a release of energy; I enjoyed being allowed to scream and make frightful noises, probably the first time in a long time. Forest chant - even more expressive than the war chant; images of primeval swamps before the dawn of man.

It was very calming to be relaxed by communicating through touch with the other people. It was hard to produce any sounds. 'Child playing' chant - I could see little girls skipping along a street in time to the music. I enjoyed half listening to the others in the group, and noticed they ended up swaying to the beat. War chant - much more primitive, and the drum beat evoked more instinctive basic sounds.

It was an interesting activity to use because it is seldom we can make noises like this....When we let the beat direct our choices, I found that it was hard not to be influenced or put off by my neighbours when they were chanting loudly.

I didn't really get into the breathing and Om-word because I was disturbed by people giggling and being silly. These can be things I am really able to enjoy. Forest chant - I was enjoying my own fantasy which didn't match the sound of others; I was irritated by their intrusion into my space instead of encouraged to join theirs.

I felt this activity was a very unifying one that tended to be a welcome progression from the spontaneous clatter of the music. With the Om I felt the commonality of mood of all present very relaxing and applicable at the end of the session. I found the various themes a good opportunity to express many inner feelings I had during the session, e.g., anger, happiness.

I was amazed at the complexity of sound that came from the group and how powerful it was,almost hypnotic.

Found the whole chanting activity very relaxing and enjoyable.

I enjoyed parts of the chanting. I felt very threatened and inhibited with our heads together, lying on our backs. I felt too close to the person beside me and it took me a long time to get into the chanting.

Chanting the Om was a relaxing and calming activity for me.

This more than anything changed my head and body space from strung out to feeling calm and much more together with myself ....The stillness in chanting helped me to decrease my earlier feelings of being fragmented and spinning.

3. Application:

If I could make or somehow acquire a drum, I think the chanting activity would be the one I would choose to do with my clients.

I could see applying spontaneous music with a small group of my patients. I work on an extended care ward. I doubt the application of chanting.

Due to my personal reaction towards the spontaneous music, I feel I would rather like to structure this activity with non-verbal groups I would be working with....Found the chant a unifying activity to use to add to group togetherness and would plan to use this activity with non-verbal groups I will be working with.

Spontaneous music to allow for the expression of feelings stifled by the spoken word....Also release of aggressive feelings. More delicate instruments allow for expression of feelings of sadness, loneliness.

Chanting allows for extension and growth of the voice beyond the usual monotonous tones.

I think it would be fun to make instruments with a group of patients and then play them. I have tried chanting with patient groups, with not much success. People have been reluctant because of discomfort of hearing their own voices. However, this session has given me some new ideas....I definitely think the drumming helps.

I feel it (chanting) allows patients opportunities to experiment with their own voice and gives physical contact and reassurance as well as opportunities for relaxation, and may give opportunities to recall past experiences for discussion within the group. I feel that the spontaneous music creates a group response feeling and an outlet for an aggressive display of others' feelings.

I haven't actually done chanting with my group. This would be a very useful activity, especially with asphasic patients. Chanting is less specific and more individual, and less threatening than singing.

Excellent for severely handicapped kids and non-communicative kids (behaviour/psychological disorders). Even those with speech problems could participate as sounds, not words, could be used. It could be incorporated into speech therapy sessions. Slow chanting could be used to calm hyperactive children and fast chanting and/or instruments for expressive outlet of aggression, anger, fear.

4. Summary:

Throughout the session, I wished from time to time we could do some dancing or gross body movement.

I was glad to be part of a group when chanting worked.

For the first time I felt a mellow, good group feeling.

I was glad that I made the effort to attend.

The evening ended beautifully and most of my earlier anxiety had disappeared.

Fourth Session

1. Frame of Mind Before Session:

I was a little tense before this session - a carryover from work.

Calm with a certain amount of expectation in learning something new, in freeing my body from its usual correct, staid stances.

I was looking forward to the evening, and was also rushed.

Feeling a little anxiety left over from an earlier experience during the day.

2. Activities:

Writing Poetry to Music

When we shared our words and drawings, I was surprised at the degree of melancholy inspired as I had sensed it myself - a lot of sad, lost, broken feelings where I had felt only positive, contented ones...some people stirred me with their words, but mostly I felt a re-affirmation of my own direction.

Got into that, really feeling the music and was able to create. Was nice to be able to share creation with others. Was good method of getting feelings into words.

I was initially apprehensive as I don't like writing at the best of times...however, once I got going, I felt okay about it.

The words came easily, flowing to the music, sometimes melancholy, sometimes turbulent, but generally leaving a feeling of peace. Hearing the people's poetry was very moving - I felt slightly embarrassed at the insights into some people that it revealed.

I liked being able to have a choice about how to express my thoughts (poetry or pictures), the sharing of our words with one another brought a real warmth and closeness to the group, and I felt that I knew people just a little better after this sharing.

Wary of this as I felt whatever came out would be surface "head", certainly not creative, but I was wrong. Had a spontaneous clear image of space, exploring, searching, moving, not characteristic imagery. The music seemed to carry me along, and the words came almost simultaneously, finishing as the music did.

Music therapy workshop was great tonight - as much as I hate sharing what I write, it really helped me feel closer to everyone...I felt more with it tonight than any prior session.

I enjoyed writing the poetry and really enjoyed the amount of personal sharing that people did with their writing or drawings.

Improvisational Dance

I felt self-conscious at first, enjoyed it as I relaxed a bit.

I found I wanted to move to the music, but I was very tired.

Music sensational as before, very peaceful. I felt very frustrated having to stand up in this activity; when I let myself 'soak up the music' I found it so relaxing that I could hardly stay on my feet.

Body Sculpturing

I did not like the body sculpturing too much as I was aware that arms held unsupported ache, so I didn't feel free to mold my partner, and when I was molded this also proved to be the case.

I wonder if it made a difference having a male as my sculptor, but I felt entirely submissive, enjoying being molded, touched, feeling a firm but gentle grasp. Was aware of some anxiety in allowing myself to be entirely at another's volition....When I sculptured him, I found I wanted to be very gentle and respectful of his body that he trusted to me.

Was aware when I was sculpting partner that I was projecting self rather than creating a symbol of her for her.

It was enjoyable being molded, a bit mystifying as I could not link the position with my picture of myself....I also enjoyed being the sculptor, it helped me analyze positions and movements as well as the personality of my partner.

I responded positively to this exercise, enjoying the intimate contact of one to one. I enjoyed the attention and care of another person sculpturing me.

Although we didn't know each other, I felt very comfortable with her touch and felt myself wanting to respond to her sculpturing. I also felt good about molding her, her body responded as soft, firm clay. We both sensed a great sharing of ourselves in this experience.

I also liked the body sculpturing, it was quite effective after the poetry.

Body sculpturing and painting was interesting because my partner was the girl I work with every day. We were able to sculpt each other as we see each other, and I found this quite revealing. This rather quiet, intimate activity followed well after the sharing and the poetry.

It was interesting to walk about through sculptures, like being in the art gallery. I was really pleased with the way C. sculptured me.

Community Painting

Enjoyed the painting but there wasn't enough room to paint - it was too crowded.

I felt there was a lot of heat and intensity in the music and drew a large flame. It was enjoyable adding to the design of others, much like a communication with others in the group.

I found I wanted my work to be distinct from others. I didn't want them to add to my work, although I wanted to add to theirs (self and quite imposing). I let out a lot of aggression. I was surprised that the overall effect was not much more aggressive.

Community painting seemed to change the mood entirely to a much more aggressive, extroverted theme. I guess the music suggested violence because of all the explosions we painted. But this was so subtle that I wasn't aware of it until I started walking around, adding to others' work.

Amazing how well the group reacted to other's paintings and added where necessary to give a group-blended effect.

Great. Need more paper though, need more time too. The music was very strong and obviously influenced our painting.

Excellent music for this communal project, however, I felt very restricted in terms of space and time.

A frustrating, unenjoyable experience - the music was too punctuated, it had no flowing lines, so that the best it inspired was chicken scratches and blobs. I felt cramped and cornered, and an utter sense of futility in painting something that others would merely smear over.

Circle Dances

I felt drained of energy rather than capturing it. I am so out of shape that I felt exhausted after about five minutes.

Step-hop mostly just a good energy release, good exercise.

I felt restricted by the step hop and wanted to do more than that. I was also totally out of breath and my lungs ached when I finished...the next day I started jogging with two fellow OT's.

By this time I was tired and it made me physically exhausted after doing the hop step. Closing eyes in tight circle made me feel close to others.

I loved the exuberance of the hop step music and found it easy to be wild and free and uninhibited. The music in the circle was a shock and I hated it, I felt it should have been a sort of hymn...I discovered my mind wandering to other things, as I was so distracted and repelled by the music that my mind sought refuge in mundane things, like I must do the shopping list, etc.

prounced in the treatment group. Two-thirds of both the treatment and control group were single.

As Table 2 points out, one-half of the treatment group and one-third of the control group had less than Grade Twelve education, while one-sixth of the treatment and one-third of the control group had greater than Grade Twelve. Only one person had completed a university degree (teaching) while two had some university. The others who had more than Grade Twelve had technical, vocational, and commerical courses - many of which were not completed. Educationally, the group represents a different picture than Day-house where the majority are university graduates. The group is also distinguished by the large number of drop-outs from either high school or post-high school educational programs.

In terms of employment, both the treatment and control group are characterized by a series of marginal, short-term jobs which require little training and which are usually poorly paid. Their employment pattern over the last year indicates a marginal revenue from their own earnings for the majority of them. Some had steady employment records for a number of years, becoming erratic in the last few years. AN example of this is a 34 year old male who was a grain elevator operator for ten years, and then did nothing for the period of time prior to admission. Another was a service representative for six months, who quit three months before entering treatment. More common are work histories that include baby-sitting - cleaning in factory for six months - and on welfare for the last twelve months. Many of the people have been laid off of their jobs. There is no doubt

I think I would use the technique of body sculpturing with patients, but giving them the choice of projecting or symbolizing.

(Many people in this session responded to the application question by abstractly listing all possible therapeutic applications. This was not the intention of the diary and therefore these items have not all been listed.)

4. Summary:

It is too bad we have to cram in so much. Why can't we have more time to fully explore each exercise. All the emotions that are aroused are just as important.

In general, I enjoyed this session above all so far in the music therapy. I felt a real sense of personal, artistic involvement as well as a beautiful sense of group sharing throughout.

A session which moved from individual to couple to group expression. The theme expressed was put into movement, words or drawings, the message given us by the music. I get in touch with feelings I hadn't allowed to happen for some time. I was reminded who I thought I was I still am.

Appendix A - Review of Activities and Music for Music Therapy Workshops

First Session

An opportunity to meet each other on a different level - to build a group with some trust and cohesion.

1) A Warm-up:

To "The Streets of Arklow" - Van Morrison.

Walk in, around and through the room. Find all the space - every corner, every piece of air, backward, forward, everywhere.

Now keep walking and add some small gesture with your arms, which is you as you walk.

Now make your walk very large and obnoxious, as big as you can, stretch out into space, boldly.

Now make your walk as tiny and discreet as possible, as small as you can imagine.

Walk as you started.

Find someone to walk with, a partner, and make a special way of walking with that person - something that is uniquely the two of you together.

Two join two others so that four walk together now. Find a new way of going through the space with the four of you. Create a certain walk.

Four join four others, etc. Then eight join eight others until there is one of all together.

2) Reflections - there is now a circle:

To Handel's "Hallelujah Chorus" and Oscar Brown Jr.'s "Brown Baby" sung by Jean Pace.

One person move as the music makes you feel. All others in the circle imitate that leader. Copy his or her every gesture and movement, to experience and share the music as that person feels it.

When one person is finished, point to someone else who you wish to take the leadership. Then we all follow that new leader, etc., until everyone has had a chance to lead.

3) Mirrors:

Choose a partner. Mirror your partner as he/she feels the music as before. Take turns leading.

To Saint-Saens' "The Dying Swan".

4) Touching - this time everyone close your eyes:

To Roberta Flack and Donny Hathaway's "mood".

Move as the music makes you feel, as a unit with your partner.

Ideally no one leads, no one follows.

5) Sculptoring:

To Debussy's "Clare de Lune".

Make yourselves into groups of four each. Choose a sculptor who takes the other three then adds himself to a frozen sculpture of people. Place the people as you see them, in posture and in relation to the other members of the group. Then when the music begins, turn yourselves into a living sculpture and move in the framework given by the sculptor, always keeping some connection to the group. End in the original frozen sculpture you started with.

6) Group Sculpture:

To Joe Zawinul's "In a Silent Way".

Now create a sculpture out of the entire group - frozen. When the music begins, again begin to move within the structure offered. Move freely, but always maintain some connection. Now scatter from the group and move to the music on your own, glad to have your own moving space without connection to others. Dance a while on your own. Now gradually return to the group and move again with the others. As the music closes, return to the original frozen sculpture.

Second Session: Freedom in Movement

1) Warm-up:

To Nancy and Carolyn's Drum music.

Stand in one place. Move as the music makes you feel. Every part of your body, find every space around you. Now put your hands behind your head and move all the other parts of your body you had forgotten about.

Now walk around and dance as the music tells you.

2) Make a circle with the rope around you:

Hold on to the rope and dance to the drum music, using the rope as you wish.

Now turn loose of the rope and place it around your hips still in the circle and dance, keep in constant touch with the rope.

3) Rope with smaller groups:

Who liked dancing with the rope a lot?

Who didn't like it?

Each group make your own dance with the rope.

4) Silhouetting:

To "Cake Walk", Taj Mahal; "Miracles", Jefferson Starship; "Chorale Prelude", Pachelbel; "Crystal Silence", Corea-Burton; "Ensemble for Synthesizer", Babbit; "Monday Bluesong", Mark Almond; "Dida-dida", Joan Baez.

Fooling around - each person go in front of the screen and spend some time to do whatever you wish.

To OBJR "Brown Baby" and Miss John Hurt's "Whoopin Blues".

Form three groups. Get together and think of a plan to use with the screen and choose your own music from what we've heard today.

5) Improvisational dance with extensions:

Find your spot in the room. Listen to the sound of your body.

Accompany your body rhythm with a small gesture. Gradually extend that gesture until it becomes very large and you are moving about the room with it. The other half of the group each finds one person to accompany with a musical instrument.

6) Find your spot again:

Create a Quiet. Pull a movement out of the quiet. Pull a sound out of the movement.

Third Session

1) Chanting:

Make a circle sitting down. Join hands and close your eyes.

Breathe - now chant Om with the group, soft, loud.

Choose one word and keep chanting and repeating your word over and over.

Take all the thoughts out of your mind. Concentrate on the theme given and the beat of the drum. When the beat has soaked into your body make a noise or sound and keep repeating it, a chant, a word, a tune, etc. Let it come from yourself, then listen to those around you and let it change according to how you respond to them.

Themes:
- Children playing together
- Stubborn kids
- War chant
- The wind
- Laughing
- Moaning and groaning
- A spontaneous chant from the group without theme.

2) Spontaneous Music:

Arrange the instruments in an orderly fashion.

Play any of the instruments floating freely from one to the others whenever you want.

Make music to these themes: A Requiem, Carnival.

Now split into two groups. Each group plays music spontaneously. While observers pick up themes, moods,messages, just as if they were listening to Beethovan's Ninth.

We compare how it felt to play and how it felt to listen.

Fourth Session - Focus on Art as an Abstraction

1) Writing poetry to music:

To Aaron Copland's "Clarinet Concerto 1".

Empty your mind of all thoughts. Concentrate on letting the music soak into your consciousness. When you receive a picture or suggestion from the music describe it in words on the paper, whether it be random words, a poem or whatever.

We share our words with each other.

2) Improvisational Dance:

Using the same music.

Find 'your spot' in the room. Take your time and walk until you find a place which is comfortable to you. Close your eyes and stand in your place. Again let the music soak into your body - to the ends of your fingertips, to your toes, through your head and let it move your body for you, slowly, gradually. Move as the music says. Now begin to dance about the room slowly. If you touch someone spend some time with that person, then move on whenever you wish.

3) Body sculpturing and painting:

To Giulliani's Sonata in A Major, Op. 85 for Flute and Guitar.

Choose a partner. Think of your partner as clay. Now mold him as you see him, having a respect for his personality and gestures, trying to create a symbol of himself for him. Then pretend to paint him in specific colors. Which colour would you use for each part of his body. Now change place and repeat the other way around.

4) Community painting:

To Art Blakely's "The African Drum Beat - Love, the Mystery of".

On one long piece of paper, choose your spot. Paint as the music tells you in your place, then move around and paint in other people's work, communicating with them through the medium of the paint and art.

We hang and discuss our creation.

5) The Circle Dances - to capture group energy:

To Rolling Stones' "Let's Spend the Night Together".

Do step hop in a circle. Do not stop. Keep going for the entire song. Only step hop. Improvise a little if you wish.

To Mother Earth's "You were here".

Make the circle tight - elbow to fingertip. Let our hands come down together to mid-waist to create another circle, then gradually separate and bring that group energy to yourself. Do not make the motion happen. Just concentrate and think about the one movement. Let it happen. All eyes closed for concentration.

Video material on the Music Therapy Workshops is available from the audio-visual section of the Department of Psychiatry, University of British Columbia, Vancouver, B.C.

Both two-hour and one half-hour versions can be borrowed or bought.

Review of Purposes for Training Workshops

Session I - Purposes

1st Activity

Walking around in the room -

Purposes:	To progress from individual to paired units to a single whole unit; To provide a simple activity (walking) which is not necessarily, but potentially, "creative"; To provide a low-key setting - mellow, clearly rhythmic music.
Uses:	To begin a sense of group, for an on-going group; To provide one model of the process of connecting with others.

2nd Activity

Circle reflections -

Purposes:	To build an experience of group support; To persuade members to get actively involved; To encourage risk "in public".
Uses:	To focus the relationship of group to individual - e.g., individual contributions can provide the whole group with stimulation and suggestions; each individual can make a unique contribution; the whole group can encourage, support and/or demand each individual's participation; To increase each person's awareness of their own body language, self-image, and discrepancies between intentions, wishes and body habits.

3rd Activity

Mirroring partners -

Purposes:	To develop a strong connection with one other person, which will carry over to the next session; To stretch everyone out, towards - being responsive to another - taking body language seriously, first another's, then maybe our own.

Uses:	To provide an encounter involving compromise of one's own self-direction. To stimulate new activities by example. To experience another person's point of view. To create a relatively intimate relation with another.

4th Activity

Movement synchronized by touch alone -

Purposes:	Same as above, but intensified. Relaxing into physical contact with a relative stranger. Focussing intensely on touch communication Escaping from objective perception (vision) into subjective.
Uses:	Same as above. Introducing physical contact with the potential range of minimal motion to extended gestures.

5th Activity

Small group sculptures -

Purposes:	To encourage a group creative effort. To experience individual freedom of motion and decision within a group structure. To explore the confines of a connected group.
Uses:	To symbolize the positions and connections between people who know each other well. To reveal group dynamics to participants and therapists.

6th Activity

One group sculpture -

Purposes:	Same as above.
Uses:	Same as above, but including everyone.

Session II - Review of Purposes for Music Therapy Activities

1) Warm-up to N. and C.'s drum music
   - -- purpose to: relax, loosen up, free your mind from all concerns in order to be receptive to activities at hand
   - -- to become aware of where your body holds tension and spend some time loosening those particular areas
   - -- focussing on "letting the music" influence you.

2) Circle dance with rope around entire group
   - -- to have a tangible representation of personality and group dynamics, e.g., submissive, dominant; aggressive, passive; give and take, etc. You can physically feel the responses you get from your action or lack of action.
   - -- a problem-solving process given to a group, usually drawing strong reactions as to what a person liked or didn't like.
   - -- for some a place to turn loose excess energy, whether it be aggressive or just needing to let off steam.

3) Rope with smaller groups
   - -- people who have similar energy inventing their own process to work out a mutually satisfying give and take situation. In other words, finding a creative solution.

4) Silhouetting
   - -- Experimenting with your body image, emphasizing things you like, changing things you don't like. Not as threatening as a mirror, because of lack of detail - this is a general image, where you may pick up personality qualities which you were unaware you projected.
   - -- addition of drama to focus and expand.
   - -- in the groups, again process, going through a complete process, solving a problem in a group situation, becoming aware of the give and take, the funtioning of your own personality becomes visible on the screen.
   - -- when it works, the positive feeling of creating and working together with others emerges, giving incentive for further interaction.

5) Improvisational dance with extension
   - -- the suggestion of growth. Extending your body and subsequently your entire personality to new experience, change and growth, starting from the most basic beat of your heart.
   - -- adding energy to the impetus you have started with the instruments, making you feel bigger than you really are.

6) Create a quiet, a movement, a sound
   - -- primarily relaxation and again growth from your own source.

Session III - Purposes

Instruments

Generally:

To enlarge our repertoire of expressive tools - to include instruments as well as words - to discover particular instruments for particular moods and messages.
To discover and encourage moods and communication not easily expressed by words.
To reveal leadership, submersion, compatibility (etc.), possibilities and tendencies within the group dynamics.
To stimulate a creative solution to group cohesion.
To illustrate the relation of individual contributions to the quality of the whole.
To challenge the pre-conception of "musician", and to open music-making to more people.

Specifically:

Individual exploration: to spend time connecting each instrument's sounds and motor demands with aspects of your personality.
Whole group ensemble: to find and sustain and develop a cohesive mood and level of activity - and exert influence or compromise so that each player feels connected to the group sound (this *could* have been given themes to provide a strong focus).
Small group ensemble: to facilitate more responsive, cohesive playing, to expand appreciation of sound qualities and moods by active audience involvement (this could have been done with more varied sets of instruments).

Chanting

Generally:

To use voice expressively without the limitations, inhibitions or strictly intellectual connotations of speech.
To use voice as a stimulant and release of body tensions.

Specifically:

On backs: To relax body, remove eye contact, increase body attention through shoulder contact; to explore voice randomly, with curiosity; to encourage open voice sounds.
Sitting - drum, themes: to evoke and recognize past experiences; to express in public private, dormant or suppressed emotions; to build a group energy which can extend individual experiences beyond usual reticence or imagination.

Session IV - Purposes

Movement and poetry to Clarinet Concerto

- relaxation.
- through relaxation recall of most dominant mood or image suggested by the music, whether tranquility or melancholy, a sad experience or a peaceful experience
- allowing your body to stretch, grow and intensify into the initial mood or feeling created by the music.
- then bridging the gap between non-verbal and verbal with the same music, describing either through recall of previous movement or new imagery, the mood or image of the music.
- sharing this with the group.

Body Sculpturing and Painting

- to focus on certain personality characteristics by making each person into a statue which clearly embodies those specific traits, again intensifying your observations with imaginary colour.
- to become familiar with and learn about others through touch.
- to become submissive and let another 'take care of' or 'create' you as they see you - for the clay.
- to become creative and clear in your observations as the sculptor.
- to talk about and to each other without speaking.

Community Painting

- to vivify and capture a group dynamic.
- to become aware of your own willingness or lack of willingness to receive and give messages in a group situation.
- to allow information which may be difficult to see to become visible in the paint.

Circle Dances

- to create a feeling of community and closeness and fun.
- to build energy through exhaustive movement.
- to resist the music, creating a tension in which to concentrate and focus on the group experience.

Appendix B

MUSIC THERAPY WORKSHOP EVALUATION

Name

Address

Phone No. Age

Place of Employment

Occupation

What is your Educational Background?

Why are you taking this course?

How did you find out about this course?

What do you hope to get from this course?

Do you know anyone else who has taken a music therapy course?

If so, what did they feel that they gained from it?

Were you strongly encouraged to take this course for professional development? Reasons?

Do you need the course for your Career? If so, how?

Do you have any idea how you will use music therapy in your job? If so, how?

Do you have any idea how you will use it in your personal life? If so, how?

Are you presently using music in your Job? If so, how?

Do you have any formal background in music? If so, what?

Are you involved in any aspect of music or dance informally, either through groups or through personal practice or fooling around on an instrument? If so, please elaborate.

If you are taking this course with other people from the same workplace, have you discussed how you want to use music therapy?

Have you been sent to represent your workplace to investigate music therapy?

Do you have any idea how this course is going to be organized or structured? If so, how?

Do you have any additional comments that you would like to make?

Thank-You

STAFF WORKSHOP FOLLOW-UP

1. Name: Date:

   Address:

2. Which sessions did you attend? 1 2 3 4 5 6

3. What were your initial feelings (e.g., apprehension, anticipation) about coming to the course previous to the first session?

4. At a personal level, which activities did you find:

   a) comfortable or threatening? Comfortable Threatening

   b) which activities did you find to be significant or uneventful? Significant Uneventful

5. What activities might you expect to be effective in working with your clients?

6. What are your suggestions for change in the workshop?

7. a) How do you plan to make use of the course material personally? Please detail.

   b) How do you plan to make use of the course material professionally? Please detail.

8. a) Did the course make a contribution to your personal growth? Explain.

   b) Did the coursemake a contribution to your professional growth? Explain.

9. Do you anticipate any problem bridging the gap between personal experience and professional application? Please elaborate.

MUSIC THERAPY WORKSHOP FOLLOW-UP EVALUATION

This evaluation is part of our commitment to the National Health and Welfare Department which funded our Music Therapy program. We would ask you to fill it out as carefully as possible and return by April 20.

1. Name

2. When did you take the Music Therapy Workshop?

3. In retrospect, what is your assessment of the strengths and weaknesses of the Music Therapy workshop?

4. Have you used the training from this workshop in your personal development? Please explain.

5. Have you ever used your training from the workshop on your job? Please explain why you have or have not used it.

   How have you used it in your job? Please give details.

6. Have you had any problems using music therapy on your job?

7. Do you feel that using music therapy has been useful? If yes, how, if no why not.

8. How do your clients/patients respond?

9. How do your co-workers feel about it?

10. How do your supervisors feel about your using music therapy?

11. Do you feel the need for any further training or information?

12. Do you have any additional comments to make about the music therapy workshop or your use of it.

Thank You.

IV

DAYHOUSE

Dayhouse

Dayhouse is a daytime treatment centre for neurotic patients. The treatment orientation is highly eclectic but focuses around the establishment of a highly integrated and intense program based on family units each composed of seven to ten patients.

The treatment program involves family and group meetings, recreation programs, work programs (all work in the preparation of food and cleaning the building is done by patients), sports, outings, some pottery, painting, and movement programs.

The music therapist, with the support of the Health and Welfare grant, has been providing music therapy sessions one afternoon a week since August. Each of the one and one-half hour sessions is attended by fifteen or twenty patients. Music therapy, like every other part of the program at Dayhouse, is compulsory and one of the obligations that patients accept when they apply for the program and are accepted.

One hundred and thirteen patients received music therapy on a regular basis since the programme started at Dayhouse. The treatment techniques used were various forms of spontaneous music; movement and dance exercises to music, including mirroring, silhouetting, sculpturing and improvisational dance; writing poetry and painting to music; and chanting (for an explanation of these techniques - see appendix A to the section on the Music Therapy workshops). Because of the higher functioning level of patients in this programme (see below) and the selective admission procedures which only accepted patients with a fairly high tolerance level for confrontation, activities were usually designed to evoke the maximum response, whether it was expression of violent feelings or creating a group supportive atmosphere.

Apart from the higher level of patient functioning in Dayhouse, another factor that distinguished it from the other treatment centre where the music therapist was working with adults (Daycare) was the fact that she had been working at Dayhouse for the previous year, so the music therapy was already integrated into the program and had general acceptance from the staff who had some understanding of it.

The limited information that was available to us about the population of Dayhouse shows a generally young, mainly female group who are almost entirely diagnosed as neurotic. Although we did not have access to detailed information (explained in the section of methodology), both the music therapist and the staff at Dayhouse confirm that it was mainly a middle-class and highly educated group.

Table 1. Daycare Patients by Age and Sex

Age	Male	Female	Total
19	2	-	2 (2%)
20-22	6	9	15 (13%)
23-25	3	11	14 (12%)
26-28	13	20	33 (29%)
29-31	8	8	16 (14%)
32-34	2	8	10 (9%)
35-37	3	2	5 (4%)
38-40	-	6	6 (5%)
41-45	-	6	6 (5%)
46 & over	3	3	6 (5%)
	40 (35%)	73 (65%)	113

As Table 1 makes clear, 35% of the patients were male and almost twice as many, 65%, were female. In the overall population over 70% are

31 or younger, while 65% of the females are and over 80% of the males. The females have a correspondingly larger percentage over 31 and especially over 41.

Table 2 gives a breakdown of the diagnoses of patients in the Dayhouse programme. These can be contrasted to the diagnosis for Daycare for documentation of the variance in patient symptoms.

Table 2. Psychiatric Diagnosis of Dayhouse Population

Depressive Neurosis	
Alcoholism	2
Anxiety	4
Adolescent Adjustment	1
Passive-Dependent Personality	1
Passive-Agressive Personality	2
Schizoid Personality	1
Anxiety Neurosis	
Drug Dependency	1
Depression	2
Reactive Depression	1
Passive-Aggressive Personality	1
Hysterical Personality	1
Schizoid Personality	1
Neurotic Depression	
Anxiety	2
Character Disorder	1
Anorexia Nervosa	1
Depression Schizoid Personality	1
Antisocial Personality	1
Personality Disorder/Schizophrenic Reaction	1
Hypomania	1
Schizoid Personality with Depression	1
Alcoholism	1

Table 2. Continued

Hypochondiacal Neurosis	1
Reactive Depression - Obsessive-Compulsive	1
Reactive Depression	1
Phobic Neurosis	1
Personality Disorder	1
Passive-Dependent Personality	1
Adjustment Reaction to Adult Life	5

In the Dayhouse programme music therapy was seen as an additional treatment modality. It was part of the on-going activity of the programme with the exception that the Music Therapist was only at Dayhouse on a part-time basis. It was viewed by the other staff as an essential part of the treatment programme, but not one which was any more important than the other parts. There was division among the staff as to whether it was the most significant form of non-verbal therapy but there was general agreement that it provided a different communication medium to the patients.

There is no information provided in this section that the music therapy at Dayhouse was any more valuable than any other form of therapy used there, or any more valuable than not receiving therapy. We did not have access to detailed patient records and there was no possibility of establishing a control group. What this section does do is explore the way music therapy is used in an on-going treatment setting and some of the ways patients responded to it. On that basis there is some evidence music therapy has an impact on individuals and on the dynamics of the group. It is important to note that unlike experimental settings that are controlled, music therapy is given in the context of the on-going dynamics of the group and affects those dynamics in such a way as to influence the rest of the treatment programme.

The development of each individual music therapy session at Dayhouse was structured around the dynamics and mood of the group at that point in time. The Music Therapist attended the group discussions the day previous to her sessions in order to get some idea of where the group was at in its development. This, in combination with discussions with the resident therapists (one in particular) allowed her to develop each session in response to the group needs.

The state of the group was characterized at the beginning of each session and then the activity explained in relation to the mood of the group.

Programmes are then developed in response to this mood. For instance, spontaneous music was used on two occasions where the group is viewed as apathetic or simply cruising along. On both occasions, however, the use of the spontaneous music went in different directions; in one it was intended to symbolize the lack of cohesion in the group and in the other to develop some cohesion within two separate groups; one centered on those who felt loud and aggressive, and the other on those who felt calm and sad.

Throughout this section, we will look at the way the various music therapy sessions were organized in response to the development of the group. This will give a greater understanding of the way music therapy can contribute to an on-going treatment program when it is only one of the treatment modalities being offered. Another major part of this section will be an examination of the patient responses to the music therapy sessions---what kinds of activities did they respond to and what were the ways they understood their reactions to the music therapy. This material will be gained from the diaries that the patients filled out each day. There is no data as has already been explained in this section of the study to assess the effectiveness of music therapy. There is a great wealth of material from the music therapist, the patients and the other therapists to give a deeper understanding of how music therapy functions and what kind of insights it generates.

A tentative and incomplete list of the functions and roles played by music therapy in Dayhouse has been developed, through analysis of the music therapist's records on Dayhouse sessions. The therapist's records of these sessions included an assessment of the group and its planned activities, the responses of the group and individuals to them and analysis of the comments that the patients made in their diaries. This list, and the subsequent elaboration of each of the items, gives a preliminary understanding of how music therapy contributes to an on-going treatment program. Even though there are unique features to the Dayhouse program that are not duplicated in most other programmes, it is still possible through this approach to get some indication of the possible roles of music therapy.

Music Therapy served several functions in the group as a whole. It strengthened group cohesion and symbolized the state of the group in such a way that people could "get a hold of it"; it encouraged confrontation and energized the group when it was apathetic; and it helped to release the blocked interpersonal dynamics of the group. From the point-of-view of the separate individuals in the group, music therapy also had beneficial effects.

It encouraged movement and the expression of emotion, especially anger, frustration, and aggression as well as affection; it focused on people's body images; it encouraged the testing of alternative realities or personalities, and encouraged the recall of long-repressed events that affected people; it allowed people to deal with interpersonal events at the non-verbal and symbolic level; assisted people to relax and enjoy themselves; and encouraged the development or exposure of new leadership in the group.

The following sections will deal with each of these elements in turn, providing material from both the therapist's journal and the patient diaries to try and uncover some of the dynamics of music therapy. In addition, the transcripts from two complete sessions, including patient comments, will be included at the end of this section. These two transcripts will give an overall sense of how the group developed as well as giving two of the most significant music therapy sessions.

I. Group Responses to Music Therapy

A. Strengthening Group Cohesion

One of the most significant examples of music therapy encouraging group cohesion is the first session that is reproduced entirely at the end of this section. In this instance, a member had left the group without consulting it, and the resulting anger and demoralization had to be dealt with. The activity planned became a very active one at the beginning in order to loosen up the group, so that it would be able to move from its anger to a cohesiveness. The details of this session should be examined at the end of this section.

B. Symbolize the State of the Group

On more than one occasion, the group would drift into a continuing mood or lethargy of which it was either unaware or which it simply did not want to deal with. On one such occasion, the group was characterized as "apathetic, unconcerned with others, uninvolved, not committed to any therapeutic gains". The idea of the music therapy session was to try to "depict in graphic, concrete form, the isolation and lack of concern present in the group and to encourage a change".

The activity chosen was spontaneous music played by each individual in his family group and listened to by the other families. Both groups produced "tentative, uninvolved, together but dull, lacking any feeling" sound. A change in the planned activity took the six group members who seemed to desire involvement in the group and put them into a group to play together. It was hoped that this group would provide "an experience in positive interaction" and "provide them incentive to carry it on".

This smaller group was able to develop a sound that was "cohesive, solid, supporting, energetic". The members of this group thus had a positive experience which they were able to describe as "shared, together, celebration, fun, involved" and at the same time provided a model or symbol to others of the benefits of being involved in the group. One patient remarked in her diary that:

> "...the second number we did with the whole group felt great. I felt we were more together, that there was input from everyone. This time I chose a small drum and drumsticks - felt more confident and began right off trying new rhythms and incorporating

> other instruments near the beginning. I really sort of lost myself to my feelings. It felt terrific. I felt free - the way I want to be - to be outside myself - not closed up."

The therapist notes on the above patient tend to confirm her description:

> "...instead of being insincere and superficial which was her usual brand of involvement, was quite solid in her participation, taking great notice of what was happening around her and responding as well as being fairly outgoing in expressing her own emotions."

One of the best activities for symbolizing the relations within the group was sculpturing. On this occasion, the mood of the group was characterized as "beginning to relate to each other more strongly, but needing a theatre in which to sample their connections or disconnections - needing an opportunity to see how they can and do relate to each other". Each family was assigned to create a frozen sculpture with the family leader "placing all members as he/she sees them in relation to all others". They were to move in and out of the structure making contacts through dance and movement before returning to the original structure. Both the participants and the family groups observing them rated the sculpture from 1-5 on how realistic and honest the sculpture and movements were. The therapist commented after the activity that:

> "...the movement did seem to offer a symbol to both families of each person's eagerness or reluctance to become involved. They saw visibly who resisted and who encouraged involvement, recognized the leaders and laggers in the family and were able to experience whatever closeness they did feel."

One patient commented that "I felt more a part of the group in music therapy and showed it through the sculpture we made. I like everyone in the group better but C". However, another patient had strong negative reactions:

> "After sculpture session in music therapy group saw me thinking I've got leprosy. I do feel like an untouchable really, dispicable. Many reasons."

The strongest reaction came from someone who designed the sculpture in his family and then could not relate to it once the family members started moving in and out, making it fluid and dynamic rather than static. The therapist comments:

> "My feeling was that he realized his involvement with people was merely on an intellectual and artistic level, but he chose to stop when it came to actually mingling with them in emotional ways."

The patient made this note in his diary:

> "Music Therapy - fun to chaos. Inside became outside and I wanted to win. Panic. Disorder. Anger. Ashamed. Realising image in video screen is the image, the me, I've been trying to kill, that I want dead, and will try to kill. Immediate withdrawal. Wanting to work it out. No time - swimming. Felt in a cloud. Only really heard C's comment - something about 'sick tragic artist'. Pain.
> The music, my 'dance', her comment. I wanted out when I'm so close to that pain.
> Pep talk from J - words. I didn't want to know - terrified. Isolation in the pool. I wanted to drown. I didn't want their fucking attention." (Immediately after the music therapy they have swimming in a nearby pool.)

As the above comments indicate, the relationship between the shift in group understanding and individual change is very close and interconnected. Every music therapy session is a different dynamic of group process and individual development.

C. Encouraged Confrontation

The mood of the group was characterized as being a lot of talk but very little movement. The idea was to "jostle" them up to give them new information about how they felt towards members of the group and towards the family structure. It was particularly important to recognize and encourage feelings of hostility and anger and to energize the group.

The activity planned for this session was to make-up the face with stage make-up in a way that portrays the deepest feeling that you have at the moment. They were then to approach various people "to exaggerate even more the feeling which they had in the accompaniment of the drums". This was done with a rope dance with the group, then with the family and eventually using the square dance where your opposite partner is constantly changing.

Patients commented on the activity in the following manner:

> "I found that I have a lot of aggression in me in music therapy today. This is quite surprising to me because usually I am so passive towards other people. I think my aggression has to do with my desperate yearning to show other people my feelings."
>
> "I like music and I always enjoy music therapy. After music therapy today I felt so relieved, the terrible headache that bothered me all day was gone and the lump in my throat disappeared."
>
> "In music therapy today I went really wild with D and scared myself by becoming so violent....Yuch! I felt small with D and felt that he and I were being aggressive and angry with each other."

Perhaps the most important breakthrough in this session was not mentioned in the patient diaries but in the therapist's notes,which was confirmed independently by the researchers' interviews with other staff members.

> G. looked like an uncaged lion as far as the type of movement he did with people. He fought with everyone, he tripped them, he knocked them down on the floor, shook them, he especially did this with men. Also involved in quite an active fighting scene

> with E., so that he wanted to spank her which he finally did in the end, but the entire time he was fighting he was laughing and giggling like a child and it became very clear that he loved to fight and we discussed it later and he said that he felt wrestling was the most natural way to relate to people and that he felt very close when he was wrestling, as it seemed like a typical case of learning, like with his brother on the streets of Paris, that this was the way to show your love, or to experience love with someone. He seemed to really enjoy the tactile, physical contact and I've never seen him look happier here and other therapists commented during the staff meeting as well...he felt very close to the people he fought with and enjoyed it a great deal. By his own admission he said that to him this was the most natural way to be close to people, was through wrestling.

On another occasion, it was felt that there was "a lot of pent-up, angry feelings in the group at this time which were not being expressed. People were given grease paint and asked to make-up their faces in the angriest fashion possible. They then walked around the room, did the square dance as previously mentioned and then picked the person that had elicited the strongest angry feeling in them during that activity, or the person in the group that reminded them of some person in their lives who they would be angry with.

The possibility of people taking on another personality and being encouraged by the drum music to act out their anger has been used and partially successful on at least two different occasions and highlights one of the methods available to encourage the expression of anger and intergroup conflict.

II. Personal Responses to the Music Therapy

A. Encouraged the Expression of Emotion

By far the most common individual comment made by the Dayhouse staff, the music therapist and the patient diaries was that music therapy allowed them to express emotions that were deeply hidden. The following comments from the patient diaries will give a sense of the role music therapy played in this release:

R. In music therapy my anger and frustrations that had been building up throughout the week seemed to be released at last. My dancing was aggressive, attacking - far from the usual timid, quiet side of myself. I was angry and it displayed itself in my screaming and yelling. The tension that I also experienced during the week released itself in the final chanting. When watching myself in the video-tape later I was surprised to see that side of myself which was aggressive.

Committee Comment, Aug. 7:
In music therapy some people showed parts of themselves not usually seen. A lot of the tensions in the group seemed to be released especially in the chanting. Sports was much more relaxed than usual afterwards.

J. I really get a lot out of music therapy. Today with my eyes closed, in my own space, I felt so free floating with the music, I began to cry. I hung on to my space when C. said to move away and touch people. The feeling of freedom wasn't so strong when I touched others but a very good feeling for others in the group replaced it, and I cried harder. Music has always touched my emotions so I must use it to get in touch with them more.

N. Music therapy was so much feeling today. Playing with musical instruments brought out so much emotion in people today. I felt elated after the conclusion. This feeling kept right through onto swimming and everybody, including myself, was in high, happy spirits.

B. Recall

One of the other important functions that music therapy has served, and one commented on by the staff at Dayhouse, was the ability of certain musical experiences to prompt recall of significant events from the past. The second transcript at the end of this section mentions two of these events. In one instance, the drum beating recalls for an Indian woman the beating of her father in tribal ceremonies in the longhouse and releases her anguish and pain in screams. In the same session, a man was able to recall his fear of the native drums one night in New Guinea. In both incidents, the recollection of these events made it possible to deal with problems that they were presently facing.

Other instances of the ability of music to encourage recall of long repressed memories are mentioned below. The recall can either release repressed material or symbolize existing problems as in the case below.

> K. Music therapy, when we say our vowels very loud I could hear how high piched my yell was and I hated it. When we were to be stubborn children (this is a chanting exercise) I put my face into a stubborn pose but can't remember my childhood. It bothers me. When we were at the funeral I couldn't do it, I stopped my feelings just like I did at my mom's funeral. I feel very bad about it because I know I missed an opportunity to express my sorrow.

> C. In Music Therapy I was alarmed initially to see the missing boat in a sea scene where my family was trapped for three days. That only represented a lack of artistic skill, but also was pointed out that I too feel I might sink and the missing boat appeared to have sunk also. It seems for years I feel I have been like a slowly sinking ship with this small hole in it and eventually I will no longer be able to float.

C. Focus on Body Images

For many of the patients in the Dayhouse programme, the music therapy session brought to the fore their problems of body image and the relationship that exists between the poor image they have of themselves physically and the generally negative impression they hold of themselves. Although different patients became involved in this question in different kinds of sessions, the two main techniques that brought this question to the surface were silhouetting and the use of playback on the videotape. It was not always clear that the patients were able to work out their anxiety or whether these sessions simply reinforced, for some individuals, these negative images.

The following comments from the patients will illustrate their concerns in this area:

S. I hated seeing myself on videotape today, and am surprised at how strong my feelings were toward that. I really couldn't stand it. There's nothing I like there to see, it made me want to withdraw into myself and away from the group - I feel really weak, and lost in the crowd, very inadequate for myself, more than the group even. I really hated it all and am scared at how much. I feel I have to do something to make myself like myself a lot more, but don't know what.

K. I didn't like the videotape. I hate the way I look just like a girl I used to hate.

P. Music therapy videotape was excellent. I saw a lot of things about myself. I noticed how bent forward my head is most of the time and will make an effort to hold it up to stop looking so submissive. At the same time that I didn't like the rigidity I show in my movements I really like my body. I was impressed how good I look with my shirt off.

J. In music therapy when people said I danced well, I didn't really take it in at first, I just kept saying how fat I looked - in my mind I was hearing it as "you dance well for someone as fat as you". When C. said, "Do you hear what is being said to you" I realized I had been blocking it out. It embarrasses me that people think I have a sensuous body and I basically didn't want to hear it. This is nonsense, because I know I enjoy dancing a lot, I like moving my body gracefully - it's mainly what I like in swimming too - but when other people notice it, I feel exposed. I know that I am still feeling very uneasy about being sensual. It is partly my fat - that I feel undesirable and therefore find it very hard to admit to having any pleasure-loving aspects to me, but it goes beyond that too, to generally feeling pleasure (even just in dancing) isn't proper. I recognize this in me and am trying to change my thinking on this. I am beginning to a bit. I at least did dance today, rather than being rigid.

D. Music Therapy Allowed People to Deal with Interpersonal Problems at the Non-Verbal and Symbolic Level

For many of the patients in Dayhouse, music therapy provided an opportunity to express their feelings towards other group members or the group in general without risking direct confrontation, and in many cases only being made aware of these feelings in retrospect through their own insight or through group discussion. The music seemed to act as a stimulant for some people and the feelings that were expressed were on some occasions a surprise to the individuals involved.

M. In Music Therapy, I had some real revelations. The most important being that I do want to be a little boy, I want people to like me enough to take care of me. If someone will protect me, help me if I'm hurt then I know they really care. Until then I'm not sure if they do like me. Another revelation was, how I come across and how I mean something are quite different. Everyone thought I was just trying to overpower and lead, yet what I was doing was

listening for someone to follow. I also saw that I do want to lead but quite often I don't know how, I don't know enough to do so, so I am frustrated when I try.
By the end of music therapy I really felt like I could be quite happy as one of the group and not the leader.

E. We had music therapy again and I still enjoy the experience of expressing myself without words....It just occured to me that because I find it so frustrating to express myself in words, it is sometimes easier to express things by moving.

S. My drawing in music therapy really scared me. I was really frightened by the realization that I make my own loneliness, yet seem to want to maintain it and draw strength from it. I love to feel accepted and loved. Once I see it is there I withdraw myself from it with great satisfaction and power. I feel lonely and unloved but totally powerful and strong. I really saw it and felt it in the music. I really do it. My feeling is that there is hurt behind the stubborness. I am hurt, I will be alone and no-one will really touch me ever. It scares me very much. Music therapy all scared me, so solitary and so empty.

E. Music Therapy Assisted People to Relax and Enjoy Themselves

There were times when the mood of the group or particular individuals within it was very intense and in the opinion of the therapists, it was necessary to provide some outlet for the intensity that had built up. On other occasions, it was the ability to feel physical release and body enjoyment that was viewed by the patients as significant.

M. Music therapy was a real breakthrough. Firstly, I felt closer to the whole group. Secondly, I got into my body movement. Didn't feel as inhibited as usual. Enjoyed dancing with B. The physical power thing is very enjoyable. All in all it's the best I've felt at Dayhouse.

Mi. I really got a lot out of music therapy today - like finding out a little more about myself, and the others; how people relate to music. It was an incredible feeling to "discover my space" - I felt so relaxed - free-floating in a timeless void - and then to put it down on paper - I never thought about what I was writing, it just seemed to come from my heart to the paper I guess you could say.

MUSIC THERAPY ACTIVITY
DAY HOUSE
January 22, 1976

Activity Planned

The activity planned today was to use the instruments with spontaneous music. The beginning was setting up the instruments throughout the room and telling the patients to go and explore each of the instruments as if they were in a bazaar, or some type of food store examining and sampling each thing as they went along taking their time and listening to sound and finding all the different possibilities for sound which they could make. This went on until I felt that most people had at least touched the instruments, since we hadn't used them in quite a while, and had some experience with very loud or very soft sounds. Then I asked people to volunteer for a committee to set up the instruments on the stage in an orderly arrangement, which they did. Then the group was asked to break into their families. Each family then played and as the family played the observers were asked to listen, to watch the group dynamics, to pick up any moods which the family put forth and the images they got from the music, and just to close their eyes and really feel that they were listening, with great respect, as if it were a classical piece. Also, before we broke into families I failed to mention that we separated the instruments into two sections: one were the louder instruments, the drums and percussion and one area was the strings and softer instruments, and people were asked to decide which group they'd like to play in without any further directions, so one group played with the drums and one group played with the strings.

Comments on the Activity

During this section where the instruments were separated into percussive and quieter sounds, in the louder sounds the focus seemed to be R. who was in the centre and using the large drums and who really seemed to enjoy being the leader. Many people commented that he looked like a strong leader, which is something he has been working on his whole time at Day House trying to not be so passive and indecisive. He looked like, and many people commented also, he was really enjoying himself. At one point he was really smiling and this is something that he hardly ever does and looks as if it was coming from a sincere place. But he really was enjoying himself, and enjoying himself in this role in particular. Then when the groups went into families, family three played first. They played music which was interpreted in two different ways: the family who played felt that they had been very close, that they had communicated, that they had all enjoyed themselves very much, with the exception of R. who, when he got into his family, took a very much of a backstage position. He said that he felt that people were requiring too much of him, especially before when they commented that he was so strong and so outgoing, and he said I'm not really that way all the time and I like to be soft and quiet sometime as well. And he also felt that he didn't want to take the leadership in the family situation and he also felt that the family was not close, that they were not playing together, which was the conclusion of the listeners. The listeners all commented that they felt that the family was isolated, that everyone was a separate person, they were not interested in playing together,they were interested in playing by themselves, they were not communicating through the music, they were not having any eye contact or closeness, the music was not connecting to each other in any type of form, and they were very critical of the family dynamics. Most people in the family were quite upset about this except for R. who agreed. In family two the purpose took a new direction in the form of J. J. had been irritated by the loud drumming before and the explorations of sounds and her comments on family three, who played previously, were that she felt it very confusing and very irritating, it made her nervous and she looked quite upset. When her family began to play she went directly to the drum herself, took a mallet but played very softly in a very tense way. She started building up the sounds louder and then when she started to build just a bit, she just went into hysterical crying, just spontaneously and said I can't do this, I can't do this. And I went and encouraged her to keep playing, and encouraged the family to keep playing with her, listening to her and going with her sounds. She was reluctant to do that but the more she did it the more rage she was conjouring up and she was crying and beating, and just beating the hell out of the drums and then she started to scream and she broke a mallet. I made her keep going on the drum and beating with her hands and she screamed, a blood-curdling scream, and then she stopped and went into sobbing and crying. We all sat around her and comforted her for a while, not saying anything, just letting her go through this physical crying and then she lay down and said that she felt that she didn't know why she was doing it, but the physical reaction she had was that there was a scream inside of her and that there was something blocking the canal for the scream to come out and that when she started playing the drum music she felt that she couldn't hold it back any more and that she felt it go through and come out her mouth and she said she felt a great sense of relief that this passage had been cleared now in her body. The only emotional thing she connected with the drumming and screaming were fear and she did mention anger as well, but she couldn't at that time associate with any person or with any particular situation.

So we let J. calm down a bit and then let family one go ahead and play. This was another very strange situation dynamically. L. wanted to play a children's song which was very good for her because she's a very sad person, unable to show any kind of joy and it was a happy, light kind of little tune. She couldn't get anyone to play with her in her family and expressed her disappointment in this, after the music. On the other hand H. got everyone quite angry with him, with his kind of sharp, snappy, quick motions on the drum, it wasn't in the form of music but more in the form of a tease and people who were listening suggested the message was I'm angry but I'm not going to let you find out about it too much, you're going to have to find out, you're going to have to pull it out of me. Because it was quite vicious the way he would hit the drum, and yet he wouldn't continue, he wouldn't actually try to initiate it as a rhythm for other people to follow, he just kind of inserted it here and there as a tempter. Both the people who were playing and the people who were listening were very angry with him for this type of teasing that he was doing and said if you're angry come on, do it and if you're going to tease us, and also if you're not going to listen to us and respond to us, just forget it. However, one thing that did continue from this was that through that drumming, J. again connected into the music and started crying and screaming again while she was watching, not as a participant but as a listener and she said as she was crying she held her head and looked straight ahead at the drum and said when I look at that drum I see my father, and then just a stream of memories and information which she hadn't revealed to the group before, about her experiences in living on a reserve and how they came and beat her father and the violence and the rituals in a long house when she was aged one to three, just came out in a continuous stream and up to this time it was a big mystery for J. that she felt a lot of anger and fear in her past and hadn't been able to remember why, or reveal anything to us and she could have gone on for hours about it. So finally the connection was made for her and she seemed to benefit a great deal from finally releasing that information and that feeling.

DIARY COMMENTS - MUSIC THERAPY ACTIVITY
DAY HOUSE - January 22, 1976

V. There is so much pain in the group right now. Being in music therapy brought it out a lot. I was in a mild state of shock at the amount of pain. Everybody seems ready to burst. It brought me down momentarily because I was feeling so good and I wanted everybody else to feel good. I know that it doesn't work that way, everybody feels their own pain in their own time.

R. During music therapy today I felt very overburdened. I enjoyed my committee work last week. This week it was burdensome and I was a member of the committee this week which was nicknamed the assassination squad.

B. In this music session I was a little upset because I realized that everything was being recorded. However, I felt before this session was ended that it was to the patient's advantage and I felt pleased. The beat H. created on the drums scared the hell out of me. It re-created a fear which I wasn't ever conscious of until now. It all happened in a small village in the Territory of Papua in New Guinea. I knew that tensions between the peoples' races were increasing. I should mention that of the ten native tradesmen with me in the village, eight were very uneasy. When one left the house at night to frequent the lavatory, eight went together carrying machetes and knives. I discovered this by accident. The night was hot and I went for a walk carrying a torch and met them. Really they met me because I didn't hear them walking, nor did I see them until they spoke to me. I asked what was the need of the weapons and they said that whenever I was not present their weapons were, they even slept with these things under their pillow. The next night the sky was black, no moon visible, it was extremely black and then it happened. The drums started. The first half hour there were different rhythms as if they were talking via drums from five different sources. Then as if by some agreed upon note they all started beating together, playing the same tune all night until it was daylight. For 10-1/2 hours this ominous monotonous rhythm lasted. I told the village people if the drumming started again, I as a tradesman would leave their place and this meant that their children would not have a school. This really hit home as they wanted a school above everything else, therefore there was no more drum beating while I was there.

T. I felt very awkward in music therapy, almost the same feelings as when I do housework with people around me. Felt very self-conscious. I felt really uptight.

C. During music therapy I played the flute for a while, the group commented on how sad I made the overall music. I did try to liven it up by quick notes, but the sounds did seem sad. I have a flute and playing it I do get discouraged because I do play sad music and I have wanted it to be happy and lively.

R. I felt really uninhibited in music therapy. It was fun and I felt like a little girl with the tambourine.

SE. Music therapy really affected me, the different sounds were making me feel so sad. The loudness of the drums was making me shrink away and so that I noticed that I was sitting away off in a corner eventually.

J. The drums got to me today in music therapy. I felt my scream coming long before I heard it. It seemed like it came from a deep tunnel and lodged in my stomach before it came out. There's still some there. I feel that, again as I write, that it's like as if it's in my head, it's frightening to know I'm going to scream even before it happens and to feel it more than hear it.

In music therapy yesterday when our family played music together, I felt alone -no co-operation from any of the others. We discussed it and all felt like that. I seemed to have the main music or song going, but no one was able to get into the rhythm of it. As I played I liked my tune but kept getting out of it to try and get into someone else's rhythm, but there wasn't any to follow. I began to wonder what's wrong with my music, or is it me or is it the others? This is how I usually react. I doubt myself first. I need to have more confidence in what I do.

MUSIC THERAPY ACTIVITY - DAY HOUSE
November 20, 1975

Mood of the Group

The group was very, very angry at coming into the session because one person had just decided to spontaneously leave the group and he had just come in to talk to the group about why he was leaving and everybody was extremely angry with him and irritated with him and his lack of response and lack of realization of the effect he had had on the group by breaking his commitment. I'd had a very pleasant, close activity planned for this session because there were about five people leaving the group this coming Friday and it was quite a challenge to decide how to bring the group feeling back after everyone was in such a temper over this young man.

The Activity Planned

The activity planned was a movement activity in which people walked alone and a loosening up exercise, to Boogey. They were instructed to walk, to stretch, to skip, to run and they could join one or another person if they were dancing to the music. Then they created a circle and they would imitate one person as he moved as the music made him feel and the others would imitate, and the leadership would change whenever the person was ready to change. Then they went into pairs and did the mirror and then they did the same with eyes closed. Then, since that was a very lyrical close-moving experience we went out again into using some more wild music "Reach Out" and they could dance alone just doing their own thing or with others, moving from one to another and then they went back to their partner which they had been with and they took turns giving each other a back massage or foot massage and then they did the circle dance of step-hop, "Let's Spend the Night Together", and then they did the circle dance of a ti-chi one hand, one movement to a rather long, fast piece of music.

Changes in the Activity

The main change was in the beginning with trying to decide how to make this transition from the angry group to the close group. So I spent a lot more time with the loosening up exercise and made it a lot more active than I had anticipated by adding the skipping and the step-hop and the running. In this way they were able to work out physically some of the energy, the angry energy they had towards X. who was the fellow who left. Also, I did continue to do things in which they were expected to demonstrate a great deal of exertion to continue this feeling.

Comments on the Activity

This was one of those rare, but wonderful activities which didn't need analysis and didn't need any explanation, it was just a very close-moving experience for the whole group. I might say that they had more fun and enjoyed themselves almost more than any group that I've had here. The combination of doing very physically demanding exercises and then taking time to relax and do massage, back and forth between these two things, really gave them a good work-out and at the same time enabled them to share their exhaustion and share their closeness. I think definitely the experience with X. had something to do with how close they did feel. His actual leaving made the group feel closer and through doing these physical activities it magnified that feeling. Some of the words that I was thinking of as they were going along with these activities were zest, joy, fun, shaking off of body tension, touch, group closeness and relaxation. I think that some of the people in the group, even though they didn't verbalize it too much, (see Patient Diary Comments for this activity) actually experienced zest for the first time in maybe many years, or some of them even for the first time in their life. They had never felt this close to a group ever and had not had that much fun in a long time.

I was especially glad that this feeling had been created because of the people who were leaving and the last circle dance is a symbol that we do of their stay at Day House and how they have to then separate from the group. But here they had had this one last time of having a really good time and feeling close to the group and then they would have this symbol as a memory in the circle dance of their stay here. Every patient commented on the activity in their diary as well as the committee. It also was good for the new group members to experience this closeness in their first days here.

PATIENT DIARY COMMENTS - DAY HOUSE
MUSIC THERAPY ACTIVITY
November 20, 1975

M. Music therapy was good today. I paired up with B. again, since our feeling from last week, that is, big brother, little sister, which has stuck. He was so gentle, touching me after he said he hasn't touched anyone for so long and he really enjoyed it.

N. Family today was something I will remember for a long time and that feeling carried into music therapy as well which was extra-super-great. There is not much more a person could ask for then what I received today from everybody at Day House. Love.

S. Music therapy was fantastic today. I was feeling so much this afternoon after G.'s workout and X.'s visit that the music made all the feelings happen. Much of it was happy and free, also very strong feelings of closeness to the group. Love, caring and trust in that love. N. was my partner for a lot of the sessions and I felt closer to him than I ever have and closer feelings of love and trust than I have ever had since starting Day House. It was like we were almost inside each other's minds. I wasn't afraid or awkward like I can be when I feel trusting and caring. It was natural and quiet and really beautiful, we both felt it so strongly. The group circle at the end was a perfect last music exercise for me. I felt all the group's togetherness and strength, I only felt lonely and sad when I took my hands away and I had the same feeling when N. and I separated our hands earlier, like I had lost something and I was alone and childlike again. It was very sad and lonely, I didn't like it but I know it's something I must face. I can feel lonely and sad at times like this and know that it's okay.

D. Music therapy is what we needed. It was happy and wild.

K. I really enjoyed music therapy again today. I really liked the dancing and feeling good with the other group members. I've found though that I am not too skillful a dancer and would really like to be. K. told R. that he was a good dancer. I was jealous.

R. I thought the group was brought a little closer together by X. leaving and after music therapy, even more so. Music therapy was good, I enjoyed the dancing and the music and there was much less separateness. I felt on display a little like I was acting, but it was not bad. I especially enjoyed dancing with G., the touching with our eyes closed was very good. After my workout in family in music therapy I felt so good, since a long time I was able to enjoy dancing without being afraid my mother was watching me, I just let myself go and felt good about it. My face muscles feel so much more relaxed. I feel so nice.

S. I will say that the best part of today's activities was in music. I enjoyed dancing and I liked this atmosphere very, very much. It was very exhausting, but I felt good afterwards. I was happy like I want my whole life to be.

B. In music therapy today I had M. as a partner in a couple of the routines we did. When M. first came to Day House I saw a good-looking, hip-type chick and I really distrusted her because of her physical self. I was very distant and withdrawn from her. She made a couple of attempts to talk with me, but I couldn't reply at any length because of the image I saw of her in my mind. Lately we've become quite close, I've allowed myself to see beneath her physical self, although I still find her very attractive physically. I've found an even more intense attraction to the person she is, the quiet gentleness she has, her ability to feel peoples' emotions and share their feelings with them. In music therapy today we worked on expressing ourselves physically and when M. and I did a couple of expressions I felt so close to her emotional as well as physically that I couldn't believe it was me. Not once did I think of her sexually. To me it was a deep and gentle emotional feeling that I've rarely experienced before in my life. It felt so good to be able to relate to her at that level. I really feel sad that I could miss that experience because I wouldn't allow myself to see the whole her. I wasted four weeks, and thank God it did happen, I'm a better person for it. M. will always occupy a place in my heart for what she allowed me to feel.

E. Music therapy was a real success. Everyone got into it and there was laughter, relaxation and fun. Maybe the upset of X. going made a stronger bond in the group, I don't know. There is something satisfying about expressing yourself with your whole body. It is very individual.

R. In music therapy the first song was a dancey melody and was about being on the road. I felt like I was hitching to California again on the road with a light feeling, no cares on my back just my packsack, nothing to think about, moving for the sake of moving and free; I'd like to be like that again, I wish I could have that feeling in daily life. In music I also had to mirror the actions of others. It was frustrating as it stopped me getting into the mood of the music for myself. I danced with E. She said I looked like a ballet dancer. That felt good. I copied E. and got a different feel for the music, like I was dancing like a male swan but her actions were softer, more like a female swan's.

Day House: Dates for Music Therapy
(assumed from dates of reports/diaries available)

Aug.	7, 14
Sept.	4, 11, 18, 25
Oct.	2, 9, 16, 23, 30
Nov.	6, 13, 20, 26
Dec.	-
Jan.	8, 22
Feb.	5, 12, 26
Mar.	4, 11

V

DAYCARE

Daycare

The Daycare treatment program is a day-time supportive program that runs from 9:00 a.m. to 4:00 p.m. from Monday to Friday. It is a part of the Health Science Centre Hospital and is often used as a pre-release program for the other residential wards in the hospital.

The patients in this program are more severely disturbed than those in the Dayhouse program (see later the list of patient diagnoses) and less committed to actively participating in any type of therapeutic program. Where the Dayhouse selection of patients is done by a staff and patient committee based on a certain ability to function and a commitment to gaining specific change in their lives, the admission referral system at Daycare is based on psychiatric assessment and a wide range of professional referrals.

Daycare puts the emphasis on very concrete changes such as learning to speak out and changing offensive appearance. The emphasis is put on supportive activities as opposed to the more confrontatory aspects of Dayhouse's program. There is less verbal analysis and more dependence on medication.

Daycare has a number of patients in transition from residential wards in the hospital complex, as well as patients who have been institutionalized for long periods of time in other psychiatric settings. Many of the patients have received treatment from private psychiatrists over the last year. This again contrasts with the population of Dayhouse, which does not often accept patients having a history of institutional treatment.

There is a very high turnover of patients in this program. This means both that there is a lack of continuity in terms of treatment and also that it is difficult to characterize the population in static terms. The therapists themselves say the patient population changed from the beginning of the music therapy to the end. Although there is no data that will confirm this, it could account for the positive change in the participation in music therapy. Initially the patients (in the treatment group) tended to be more severely disturbed and more heavily drugged, whereas towards the end of the treatment there were two types of patients polarizing - one the more chronic long-term patient, the other, the less disturbed borderline neurotic. Music therapy in this setting was developed to encourage a meaningful response from the patients without over-threatening them in some area which might precipitate a psychotic break. This problem was constantly being assessed with the staff of Daycare. Part of the focus involved greater emphasis on group supportive experiences and more structured activity and less emphasis on individual exercises. The intention was to give the patients more solid support and strength.

The techniques that were used in the music therapy program included various forms of spontaneous music, movement and dance techniques including mirroring, silhouetting, sculpturing and improvisational dance; writing and painting to music; and chanting. The music therapy program began in August and continued until the first week of February. During this period of time, 47 patients went through the program, but only 25 remained long enough to qualify for the research. Because of the dual decision-making structure in the Daycare evaluation at this time, the Director of Daycare and the research evaluator, the research assistant was given opposite instructions on follow-up testing with the 16PF which resulted in the loss of 13 people in the treatment sample.

Music therapy sessions were initially held three times every two weeks until Christmas and then, because of scheduling problems, at HSCH, they were changed to once a week.

According to the music therapist, Daycare staff attended the sessions and seemed to participate from a personal perspective for a long time before they started to understand the impact of the techniques on their patients. There was greater staff participation than existed at Dayhouse and this contributed to the program gaining wide acceptance by the Daycare staff even though they did not have previous experience with it.

Research Evaluation

Daycare staff experienced the usual difficulty in accepting the necessity of evaluation research. A major difference in this instance however was the interest of the Head of the program in evaluative research. He had previously conducted an evaluation research program to test the various treatment components of Daycare. He had been involved in developing a computer program to assess the data he had collected, and expressed hopes of receiving additional funds to refine the computer program.

This common interest in doing evaluation research led to an agreement to jointly participate in an evaluation which would assess the Daycare program and music therapy as one component of it. The agreement was that we would jointly develop the questionnaire, the music therapy researchers would provide the interviewers and would code the interview and Daycare would cover the cost of writing the computer program and the cost of computer time.

The main orientation of the research was a behaviourally oriented questionnaire (Appendix A - this section) to be given prior to admission, immediately upon release,and in a three month follow-up.

Additional research tools included the administration of the 16PF personality factor test to patients as they entered the program and immediately after they terminated. The importance of this instrument was the high degree of reliability that had been established in previous tests and the sixteen personality traits that were tested. It was felt that this would allow us to determine both on an overall basis and on the basis of each characteristic whether any change had occurred. It would then be possible to establish not only whether or not the music therapy was having any impact but also on which personality traits it was most effective. Patients and staff were also to be encouraged by the staff to maintain a weekly problems list.

A major problem concerning the research at Daycare was the question of a control group. Like the Dayhouse, they were opposed to having a control group which would divide their patient population and cause additional friction between the patients. On the basis of the estimates on the number of patients in a year provided by the Head of the Daycare it was felt that it would be possible to have a treatment group for the first half of the year and a control group for the second half. On the basis of previous patient population, there would be 50 in each group. This was compromised with the staff at the Daycare Centre in order to allow the evaluation group to have a control group while at the same time not interferring with the treatment program of the centre.

The solution was not entirely satisfactory from the point of view of evaluation. First, there was no control established to assure that the control and treatment groups were composed of similar populations. Although the 16PF test showed no significant differences in the personality factor analysis of the two groups, there were major differences in the social composition of the two groups. Secondly, different times of the year are known to have higher rates of emotional disturbance among the population and variable likelihood of improvement. Christmas and shortly after are seen to be particularly bad periods, while the summer is better than average. The two groups are not, of course, equally divided over these time periods.

Closely connected with the second difference, the third major difference is the difference between groups at different periods of time.

As patient populations change over a period of time, the mood of the group and its therapeutic possibilities and the severity of the illness of the patients also changes. The treatment and control group are therefore subject to different environments and possibly different staff.

Despite these various limitations, it was decided that this was the best arrangement that could be made to conform to the requirements imposed on the project by National Health and Welfare in regards to evaluation of Music Therapy. These arrangements were, however, severely weakened by two problems. The Head of the Daycare program, because of pressures from some medical exams that he was writing and his failure to get funding for his evaluation program dropped out of the agreement, leaving the music therapy program with a questionnaire which was only partially relevant to its purposes, no computer program, and a lack of proper coordination in the collection of some of the other necessary data. The second problem was the very high incompletion rate in the Daycare program, resulting in a longer than anticipated waiting period to get a treatment group sample of only twelve. This took from mid-August through to February. In February it was necessary to begin the control group in order to have at least an equal number to those in the treatment group. This was not accomplished until the end of April, and even then a number of people in the control group were still taking treatment when we had to cut it off to start the evaluation. The combination of the loss of Daycare participation and the lengthening of the time due to the high rate of drop-out made it impossible to conduct the follow-up questionnaires that had originally been proposed. The capacity for thorough analysis no longer existed, the small sample made results ambiguous, the patients seemed to be highly transient and therefore very difficult to track down for the three month follow-up. It would have been necessary to extend the evaluation component throughout the entire summer in order to have a sufficiently large sample and sufficient post-treatment time.

The evaluation component of the Daycare program received a number of blows which have substantially weakened the possibilities of a thorough evaluation. The major data available on which to base an evaluation is the results of the 16PF test which have been thoroughly computer analyzed, the assessment of the staff as to the effectivenss of music therapy in their program, the self-evaluation of the patients as to the effectiveness of the various aspects of the treatment program they had just undergone and the music therapist's notes on the mood of the group, her reasons for planning the music therapy activities and her assessment of the results.

The administration of both the 16PF and pre- and post-questionnaires by the research-assistant was more complicated than expected. Many of the patients were so severely disturbed or so heavily sedated that they had great difficulty with the questionnaire. The interviewer often had to have them come back for another interview and some of the patients were unable to complete their interview.

Study Sample

The 24 people who comprise the study all had a minimum of three weeks of therapy at the Daycare centre, and at least three Music Therapy sessions. Appendix A of this section gives the attendance breakdown for all patients in the Daycare program for the duration of the treatment period, and the initial and end date for those who were there during the control group period. The analysis in this section only refers to the 24 who stayed in the program. It was originally the intention in the joint study with Daycare to analyze the entire population. This was not done because of time pressures.

Table 1 gives the patients' breakdown by age and sex. It is interesting to note that the proportion of male and female patients are exactly reversed in the treatment and control groups. Also the number of patients over 35 is larger in the control group than in the treatment group.

Table 1. Patient Population by Age and Sex

	Treatment Group		Control Group	
Age	M	F	M	F
20-22	-	1	-	3
23-25	1	3	1	2
26-28	1	-	1	-
29-31	1	-	-	-
32-35	4	-	1	-
36-40	-	-	1	1
41-45	-	-	-	-
46 & over	1	-	-	2
	8	4	4	8

It should also be noted that the average age of the female patients is younger than the male patients. This is the case in both groups, but more that there is a strong connection between their erratic work history and the disturbance that has placed them in Daycare. However, a great deal of information would have to be available before it was possible to determine the direction of the relationship for each patient. Disturbance has undoubtedly caused people to quit or lose their jobs but the high unemployment rate and the consequent insecurity, as well as the poor pay and working conditions associated with the marginal jobs people with little education are able to secure, has undoubtedly contributed in many instances to the disturbance of many patients.

The following list will give some indication of the work histories of the Daycare patients in this evaluation over the last year.

Treatment Group

- several jobs in parts and maintenance, each lasting 3-6 months
- carpentry training for one week, three months ago
- gas maintenance - on and off for twenty years
- taught school for a couple of years
- been at Riverview most of last year
- kitchen help for five months
- car hop briefly, car wash briefly (doesn't remember details)
- various boutiques and nightclubs
- waitress a few months a year ago
- security guard for four months
- bus driver for year and one-half
- service representative for six years until three months ago

Control Group

- delivering pizzas and construction
- stenographer off and on
- part-time cleaning
- housewife, secretarial and sales jobs now and then
- cook on fish boat two summers ago
- babysitting and cleaning in a factory
- nothing last two years, audited at Eaton's two years ago
- junior clerk for two months
- business machine maintenance for three and one-half years
- nothing for last three years. Been in Riverview for ten months until the fall of 1975
- grain elevator operator
- kitchen assistant.

Not unexpectedly, the income of the patients over the last year is very low, substantially below the average for Vancouver. Table 3 gives the income breakdown. Significantly, three people had no idea what their income was for the last year.

Table 3. Study Groups by Income Level

Income	Treatment Group	Control Group
No Answer	1	3
0	-	3
$1,000-2,000	3	2
$2,001-4,000	3	2
$4,001-6,000	-	-
$6,000-9,000	2	2
$9,001-12,000	2	-
Over $12,000	1	-

The present source of income for the total study group was mainly welfare (46%), UIC (21%), sick pay (21%), savings (8%), and parents (4%). There was almost no difference between the treatment group and the control group.

Twenty-five percent had not received treatment over the last year while the rest had a range of psychiatric assistance during the year. Of the six who had no treatment, four were in the treatment group, and two in the control group. Again this contrasts with the Dayhouse program where the selection procedures used result in a few patients who have had previous treatment, especially institutional treatment. The previous psychiatric help for each of the groups is listed below:

Treatment Group
- Psychiatrist for five years, Daycare four months last spring, Hollywood before that (ECT)
- Psychiatrist once in a while/Crease Clinic last spring, HSCH last summer
- Psychiatrist sporadically, VGH 3 weeks recently
- Riverview most of past year
- East 2 HSCH last three months
- VGH, HSCH-74-East ward 1, Outpatient since then
- Community Care Team for several months
- Private psychiatrist, Riverview winter 1974-75

Control Group
- Community Care Team for two months since July 1975, hospital for a few weeks in summer of 1975
- Psychiatrist a few times
- Psychiatrist (where she works) for counselling
- Six psychiatrists since 1970, Crease for three months 1969
- 1968 nervous breakdown
- Ward E2 November 1975
- Valium from family MD
- Several short term stays in Burnaby last summer, visits after that
- VGH - 7 weeks, E2 - 8 weeks then Daycare
- Ward W1 for several weeks, nothing beofre this
- Riverview 10 months till Fall 75 then West side CCT

References to wards E1 and 2 and W1 are all wards at the Health Sciences Centre Hospital at UBC. Daycare is often used as an intermediary for patients coming from residential programs.

Patients were asked why they became involved in the Daycare program. The interviewer notes that many of them were unable to clearly explain their presence in the program. The answers they gave to the question all indicate an understanding of their admission only at the level of their own feeling of anxiety with apparently little insight beyond that.

Treatment Group
- anxiety, tension, shy, absent-minded, don't like taking orders
- to socialize more, speak up, iron out anti-social behaviour, give me a routine
- because I was referred here. Long time problem with depression

- -- anxiety attacks, anxiety, tension, problems in relations, express myself better
- -- referred here, express myself acceptably, relate to others better
- -- husband found somebody else - depression and psychotic episode
- -- extreme anxiety, depression, self-doubts, trouble expressing self
- -- confusion, depression, self-doubts, needs routine and structure
- -- socially anxious, anxiety attacks
- -- can't cope, depressed, anger builds up, need self-confidence, respect
- -- loose control too easily, anxiety, insomnia, marital discord
- -- depressed, no self-confidence, can't relate to people

Control Group

- -- depressed, nervous, shy, withdrawn
- -- depressed, tense, conflicts at work, can't concentrate, lack of self-confidence
- -- to get past programs eradicated, e.g., fear of people, find out who I am
- -- depression, temper, find out who I am
- -- occult powers pulling me back to Ottawa. People turning away from me. Feel dead inside. Can't concentrate
- -- non-specific anxieties, need self-confidence
- -- attempted suicide, felt unstable, alienated
- -- need to be with people again, get myself going again
- -- to socialize again, to understand other's problems
- -- learn to understand people's problems. Vague difficulties re self, depression, withdrawal, can't concentrate
- -- El said that I would benefit from Daycare, lack of self-confidence, anxiety

A comparison of the diagnoses of the two groups does not indicate any difference in the degree of severity of the two groups. In the treatment group, two patients, both with rigid behaviour, were mentioned as patients who benefitted from music therapy by relaxing them.

Evaluation

There were three main sources of data for the evaluation of this treatment program. The first data source was the results of the 16PF test. The second was the patient self-evaluation on the post-treatment questionnaire along with the few comments from their diaries (the diaries played a much smaller role in Daycare than in Dayhouse, they were to be completed weekly but were not encouraged sufficiently and the patients were much less articulate). The last source was information from joint Daycare staff-therapist meetings (which were recorded) when patient response to music therapy was discussed. These formal meetings occurred twice over the period of the music therapy treatment and informally quite often as two of the Daycare therapists often took part in the music therapy sessions with the patients.

Patient Evaluation

When patients were asked how they felt about the treatment they received in the Daycare program, six were very enthusiastic, twelve were mildly enthusiastic, five were indifferent or had mixed feelings and one was very negative (claiming that his problem was the result of a thyroid condition that had been cured). The response between the treatment and control groups was nearly identical. Two treatment and four control group members were highly enthusiastic while seven treatment and five control were mildly enthusiastic.

Patients were asked which parts of the program they gained more from than other aspects, and which did they feel were the biggest help in dealing with their problems (combining question 7 and 11 on the questionnaire). Table 6 indicates the number of times each activity within the Daycare program was mentioned in response to these questions:

Table 6.

Commitments	Treatment Group	Control Group
Exercises	-	3
Music Therapy	6	-
Recreation	2	3
Yoga	-	2
Folk Dancing	3	2
Ward Rounds	2	3
OT	1	-
Non-Verbal	2	3
Discussion	8	3
Relative Group	1	2
M and W group	-	1
Work Projects	-	-
Weekly Review	1	-
Outing	1	2
Special Interest	-	-
	27*	24*

*Up to three activities were taken from each patient. The maximum number of items mentioned would then be 36.

In the treatment group, music therapy was mentioned the second largest number of times as the aspect of the program that people found most helpful. Although there is no way of knowing the reason, the members of the control group spread their choices for the most helpful aspect of the program far more widely. Discussion groups, which received the most mentions in the treatment group (8), received only three in the control group, which was the most any activity was mentioned here although several activities received three. It would be worth assessing in some future research whether one effect of music therapy is to make group therapy more satisfactory by providing another and non-verbal outlet for the patients.

Patients were asked to rate the activities listed above on a scale of one to five for their degree of enjoyment of the activity and, also rate on a scale of one to five the extent to which they found the activity helpful. The lower the rating the greater the enjoyment and the greater the help. Table 7 presents the results of this question:

Table 7. Enjoyment and Helpfulness of Activities

Patient	Enjoyment					Helpful				
No.	$\bar{X}^e$	M.T.[a]	Disc.[b]	Rec.[c]	Ex.[d]	$\bar{X}$	M.T.	Disc.	Rec.	Ex.
10	2.57	4	2	3	3	2.64	5	2	3	3
13	2.78	4	3	2	3	2.50	2	3	2	3
25	1.57	1	2	1	1	1.21	1	1	1	1
26	2.46	2	1	4	1	2.15	1	1	3	2
28	2.64	1	4	2	2	2.28	1	4	1	1
32	1.92	1	1	2	2	2.14	1	2	3	3
34	2.28	1	2	3	1	2.00	1	2	1	1
35	2.35	2	3	1	4	2.42	2	2	1	4
36	2.42	1	2	2	2	1.92	1	2	1	1
38	1.35	1	1	2	2	1.35	1	1	1	3
40	2.71	2	2	2	2	2.42	1	1	3	3
42	2.35	1	1	1	2	2.21	1	1	1	3
	$\bar{X}$	1.75	2.00	2.08	2.08	$\bar{X}$	1.5	1.83	1.75	2.33

Footnote to Table 7:
a - Music therapy, b - discussion group, c - recreation, d - exercises, e - $\bar{X}$=mean. This table shows the ratings for the highest activities and their average score. The mean in the far left column of each individual is the average of their score for all of the activities listed in Table 6. The post-questionnaire for patient 25 was missing when the final tabulations were done.

This self-rating by the patients indicates that music therapy received the highest average score of any of the activities both in terms of patient enjoyment and helpfulness. The rating music therapy received from each patient with the exception of two patients was higher than the mean of their rating of all activities. Discussion groups, which received the largest number of references in the prior open ended question, received a lower average on both questions.

The responses to the question that sought to determine whether some of the music therapy activities were more enjoyable or helpful than others were inconclusive. Rope dance was mentioned twice, writing to music three times, poetry to music once, instruments once (with one person saying they enjoyed everything but the instruments), trust exercises, improvisation, painting, mirrors, video feedback, and circle activities were all mentioned once. It is interesting to note that the two people most dissatisfied with music therapy rated the rope dance as the most enjoyable. Two people said everything was enjoyable and one said that nothing was more enjoyable than anything else. In terms of being helpful, a similar list was created with two people saying that some things were more helpful than others but they couldn't remember which ones, two saying that no activity was more helpful. Three people said that drawing to music was helpful, three said writing to music, two said painting to music and each of the following activities were mentioned once; shadow dancing, free play, reflections, mirrors, dancing, sculptures, sharing after, video feedback, and trust exercises.

In an attempt to get additional information on how they rated music therapy, we asked them what they thought of the last session. One person was very enthusiastic about it, six were mildly enthusiastic, one was indifferent, one was mildly negative, one couldn't remember, and two said that it was very sad knowing that it was the last session.

Evaluation from the 16PF

The 16PF was used in order to determine whether or not there was any change in any of the sixteen personality factors that the tests measured. It permitted an assessment of music therapy not simply on the basis of one overall criteria of success or failure but allowed a more detailed examination which permitted the determination of whether music therapy was more successful in certain personality areas than in others.

As has already been explained, the test was administered on a pretest and post-test basis to all patients in the Daycare program. The treatment group existed for five months and the control group for three months. The time period was not overlapping but sequential. This means the difference between the two groups is greater than simply the presence or absence of music therapy. It was possible to have a shorter period of time for the control group because the same mistake was not repeated and the 16PF was administered immediately on the discharge of each patient. It was also necessary to have a shorter period because the deadline for the study had already passed.

The 16PF is a personality factor test that has been extensively used and has been demonstrated to have a high degree of internal validity. The test measures sixteen different and independent dimensions of personality, and according to its designers, it "has proved that taking into account all sixteen dimensions of personality gives better predictions than are obtainable from single scale tests". There is an A and B form to the test. Users are encouraged to use the two forms together, but if time is short it is possible to use only one form. The degree of reliability is increased by the use of the two tests in combination.

Because of the short attention span of many of the patients at the Daycare centre, it was decided to use only the A or B form of the test. Both forms of the test were used and the forms were randomly assigned to the patients. The same process occurred in the follow-up. The sixteen different dimensions or scales are essentially independent. This means that the correlation between two factors is usually negligible and that "having a certain position on one does not prevent the person having any position whatever on another. Thus each of the sixteen scales brings an entirely new piece of information about the person, a condition not found in many multidimensional scales."

There are between 10 and 13 items for each of the sixteen factors, except for general intelligence. Three alternative answers are provided for each. This is done since the "two alternative 'forced choice' situation, forbidding any 'middle of the road' compromise, tends to force an incorrect distribution of attitudes."

The internal validity, if form A and B are used together, is .11. For the single forms (which we are using) it is .67. The test-retest reliabilities for the sixteen factor scales average about .75 for a single form and .86 for the combined (A and B) forms. The range for individual items on the combined forms is .72-.94.

An external validity for the test cannot be meaningfully calculated since the test is a multiple-purpose one and each of the factors is independent of the others. There have been a number of profiles established for various occupational groups and norms established for various populations. These, however, were not relevant to our research, since we were only interested in determining whether or not the music therapy in the treatment group resulted in a change in any of the personality factors measured by the test.

The sixteen personality factors measured by the test are outlined below. It is important to remember that each of these factors is independent.

Factor A	RESERVED, detached, critical aloof, stiff, (sizothymia)	OUTGOING, warmhearted, easy-going, participating, (affectothymia)
Factor B	LESS INTELLIGENT, concrete thinking, (lower scholastic mental capacity)	MORE INTELLIGENT, abstract thinking, bright, (higher scholastic mental capacity)
Factor C	AFFECTED BY FEELINGS, emotionally less stable, easily upset, changeable, (lower ego strength)	EMOTIONALLY STABLE, mature, faces reality, calm, (higher ego strength)
Factor E	HUMBLE, mild, easily led, docile, accommodating, (submissiveness)	ASSERTIVE, aggressive, stubborn, competitive, (dominance)
Factor F	SOBER, taciturn, serious, (desurgency)	HAPPY-GO-LUCKY, enthusiastic, (surgency)

Factor G	EXPEDIENT, disregards rules, (weaker, superego strength)	CONSCIENTIOUS, persistent, moralistic, staid, (stronger superego strength)
Factor H	SHY, timid, threat-sensitive, (threctia)	VENTURESOME, uninhibited, socially bold, (parmia)
Factor I	TOUGH-MINDED, self-reliant, realistic, (harria)	TENDER-MINDED, sensitive, clinging, overprotected, (premsia)
Factor L	TRUSTING, accepting conditions, (alaxia)	SUSPICIOUS, hard to fool, (protensia)
Factor M	PRACTICAL, "down-to-earth" concerns, (praxernia)	IMAGINATIVE, bohemian, absent-minded, (autia)
Factor N	FORTHRIGHT, unpretentious, genuine but socially clumsy, (artlessness)	ASTUTE, polished, socially aware, (shrewdness)
Factor O	SELF-ASSURED, placid, secure, complacent, serene, (untroubled adequacy)	APPREHENSIVE, self-reproaching, insecure, worrying, troubled, (guilt proneness)
Factor Q1	CONSERVATIVE, respecting traditional ideas, (conservatism of temperament)	EXPERIMENTING, liberal, free-thinking (radicalism)
Factor Q2	GROUP-DEPENDENT, a "joiner" and sound follower, (group adherence)	SELF-SUFFICIENT, resourceful, prefers own decisions, (self-sufficiency)
Factor Q3	UNDISCIPLINED SELF-CONFLICT, lax, follows own urges, careless of social rules (low integration)	CONTROLLED, exacting will power, socially precise compulsive, (high strength of self-sentiment)
Factor Q4	RELAXED, tranquil, unfrustrated, composed, (low ergic tension)	TENSE, frustrated, driven, over wrought, (high ergic tension)

An analysis of variance test was done testing each factor separately, between pre- and post-test results, and between treatment and control groups. The test that was done produced a level of significance for any pair within those four items. The results of the test are indicated in Table 8 which lists each of the personality factors and the level of significance attained.

Table 8.

Reserved-Outgoing	.17
Less Intelligent-More Intelligent	.63
Affected by Feeling-Emotionally Stable	.41
Humble-Assertive	.52
Sober-Happy-go-Lucky	.76
Expedient-Conscientious	.28
Shy-Venturesome	.77
Tough-Minded	.97
Trusting-Suspicious	.76
Practical-Imaginative	.06
Forthright-Astute	.69
Self-Assured-Apprehensive	.92
Conservative-Experimenting	.95
Group-Dependent-Self-Sufficient	.006
Relaxed-Tense	.87

Statistical significance simply indicates to us that certain sample differences would not occur very frequently by chance if there were no differences whatsoever in the population. The level of significance used, because of the small size of the sample, was .01. In other words, the possibility of the differences appearing by chance are one in a hundred. Such a high level of significance is required when the sample size is so small, a larger sample size allows for less chance of variation existing because of the composition of the sample population. It will be noted that all of the levels of significance are below .99 and many are a great deal below this level. The null hypothesis tested here is that music therapy does not make any difference. The result of this test, then, is that no change in any of the personality factors is evident at a statistically meaningful level that can be attributed to music therapy.

Therapist's Comments

Although the patients at Daycare did not maintain a diary as did the patients at Dayhouse, there was still a great deal of descriptive material gathered in the form of the therapist's comments. Like the descriptions of the activities at Dayhouse, these descriptions included an assessment of the mood of the group, an outline of the activities planned and a discussion of the response of the group and the individuals.

As noted throughout this section, the patients at Daycare are considerably different from those at Dayhouse. Although many of the activities were conducted at both Daycare and Dayhouse, the response of the two groups was different. Looking over the transcripts of the two groups, two major differences are apparent. First, the music therapy meetings for the first two and one-half to three months were directed towards the group as a whole, with less emphasis on individual activity. This mainly involved establishing situations that would give the patients some sense of collectivity and mutual appreciation of the similarity of their situation and support for their individual attempts to deal with their problems.

Secondly, the music therapist focused many of the activities on what she called "concentration, stimulation, interaction and activation". The goals of these activities were much more fundamental than similar activities in Dayhouse. At one point, the therapist described the difference between the same activity in the two centres in the following way:

> The basic intructions for the activities used are the same. However, the length of time taken by each particular activity is more extended here in Daycare than it is in Dayhouse. It takes Daycare people longer to get involved and to express themselves. It's important that they have an opportunity to complete anything they start within the activities.

The orientation of the early music therapy program then was determined by the severity of illness of the patients, the newness of the music therapy program in this setting, and the type of program patients were in. The major direction of music therapy was simply to get people moving, get them active in order that physical movement might provide the energy to allow people to deal with their problems.

The entry in the therapist's notes for September 15 is typical of this earlier period :

> Mood of the Group:
>
> The mood of the group is disconnected. There seems to be little connection with patients, people preferring to keep themselves as isolated as possible.
>
> Comments on the Activity:
>
> The first part of the activity was a warm-up. I found it most difficult to have people use their bodies--both because of isolation, and nervous tension. Their bodies were rigid and medications used had a delaying reaction for several people in the group.

It is difficult for patients to respond openly when heavily sedated.

On another occasion:

> The mood of the group is quite disconnected and isolated. People are relating to each other in a superficial manner. This activity was constructed primarily to jolt that superficial connection and to get people to feel closer, to establish a physical connection which will then be carried over to other aspects of their program.

Discussing this session, the therapist notes problems typical of this period:

> Most important is the development of trust within the group. Relating to someone through touch or movement creates a different type of closeness than experienced in verbalization. . . Especially in this program with many people either having been isolated for years or being on severe medication which actually hinders their ability to connect to their environment.

At least from the music therapist's point of view, the initial insights of the patients were oriented to a very elemental understanding of the dynamics of the group, and more secondarily to personal insights. This, of course, reflects the quite low level of activity in the group. Comments from the early period include:

> It (the "antics" of a small group of male patients) seemed to offer a good example of how a particular clique in the group could hinder the progress of other group members. Through the physical battle of the ropes (rope dance), it became quite evident that it could be a factor worthy of more consideration than it had been given so far.

On another occasion early in the use of Music Therapy:

> The discussion in this group was quite good for it made visible the group dynamic which was important to all in the group. . .

After a session in which they walked to the sound of the music, walked big and small, added a unique gesture, joined in pairs, foursomes, eights, then followed leadership of one person in the circle, then mirroring, the following comment was made:

> As therapist in the group, I felt that it had created a positive interaction among group members. This was discussed with the other therapists in the program. They were asked to watch for signs of a carry-through the following day. They mentioned at a later date that it had continued throughout the week.

Over a period of time, patients began, according to the music therapist to understand their isolation. A note on October 15 emphasizes this:

> The general reaction in discussion was that people did feel loneliness and were moved by the times there was a connection with others. For example in the first group there was a positive interaction which was important for the observers(other group members) to see. It thus became a goal for the observers as well. (This followed a silhouetting activity and then creating a frozen sculpture in small groups of four or five to music picked by that group.)

A transition point in terms of the organization of group activity and developing a sense of interaction was encouraging group members to experience each other physically through touch or other forms of body contact. It should be emphasized here that although this evaluation seems to be implying a linear development of the group, this was not in fact the case. Movement was sporadic and not everyone in the group moved at the same rate, of course. This should not, however, obscure a general trend that both music therapist and resident therapists observed. Touching, then, was an important, but for many patients a difficult, step to take.

> The goals for the group are concentration, tion, stimulation, and inthis particular activity, also having a good time with moving, playing relaxing, then gradually working into touching each other on a physical level. The hope is that results would carry over into other parts of their program as well. When that bit of closeness was established, they were encouraged to express some parts of themselves which might be difficult to express, but which by the end, they would have built up enough trust to do so.

The activities in this session included swinging statue game, pairing off - with each person taking turns being a lump of clay to be molded, or being a sculptor molding the person into their image of them. The third part of the session was chanting.

Throughout the sessions at Daycare chanting was actively used, much more than at Dayhouse. It appeared to allow a physical release and forced people to use their voices. The evocative power of this particular activity was demonstrated in this session. (October 20):

> D. commented that in actually making these sounds and having permission to feel like being a child again, he remembered quite a lot of indicents and the feelings that went with them and it made him frustrated and angry. . .
>
> In the war chant, I. was the most vocal of the lot, even though other people were able to make rather fierce sounds, he seemed to get the most out of it and be able to express himself the most. He said that being able to get that sound out of his body made him feel more relaxed and that he could actually scream and turn loose of it.

On another occasion:

> The mood of the group is quite disconnected and isolated. People are relating to each other in a superficial manner. This activity was constructed primarily to jolt that superficial connection and to get people to connect and to feel closer to one another, to establish a physical connection which will then be carried over to other aspects of their program.

Discussing this session, the therapist notes problems typical of this period:

> First of all, is the learning of trust in the group, relating to someone through touch or movement instead of through words creates a different type of closeness than experienced in verbalization....Especially in this program with many people either having been isolated for years and years or being on severe medication which actually hinders their ability to connect to their environment occasionally.

At least from the music therapist's point of view, the initial insights of the patients were oriented to a very elemental understanding of the dynamics of the group, and more secondarily to personal insights. This, of course, reflects the quite low level of activity in the group. Comments from the early period include:

> It (the "antics" of a small group of male patients) seemed to offer a good example of how a particular clique in the group would possibly be hindering the progress of other group members, and then this more or less physical battle of the ropes (rope dance), it became quite evident that it could be a factor worthy of more consideration than it had been given so far.

On another occasion early in the use of Music Therapy:

> The discussion in this group was quite good in the sense of making visible the group dynamic which was very important to all of those involved in the group at the time....

After a session in which they walked to the sound of the music, walked big and small, added a unique gesture, joined in pairs, foursomes, eights, then followed leadership of one person in the circle, then mirroring, the following comment was made:

> As the therapist in the group, I felt that it had created quite a positive interaction among group members. This was discussed with the other therapists in the program. They were asked to watch for signs of a carry-through the following day. They mentioned at a later date that they felt it had continued throughout the week.

Over a period of time, patients began, according to the music therapist to understand their isolation. A note on October 15 emphasizes this:

> The general reaction in discussion was that people did feel the loneliness of not relating to each other and they were also taken by the times that there was a connection, for example in the first group, and having this example where there was positive interaction was very important for the other groups to see. It becomes a goal for them, for many of them. (This followed a silhouetting activity and then to create a frozen sculpture in small groups of four or five to music picked by that group.)

A transition point in terms of the organization of group activity and developing a sense of interaction was encouraging group members to experience each other physically through touch or other forms of body contact. It should be emphasized here that although this evaluation seems to be implying a linear development of the group, this was not in fact the case. Movement was sporadic and not everyone in the group moved at the same rate, of course. This should not, however, obscure a general trend that both music therapist and resident therapists observed. Touching, then, was an important, but for many patients a difficult, step to take.

> Again the goals of the group, as always, are very much concentration, stimulation, interaction with each other, and in this particular activity, some of the added things were just having a good time with moving, with playing, with relaxing, then gradually working into touching each other on a physical level,

> hoping it would carry over into their other parts of their program as well and then finally, when that bit of closeness was established, go into exposing some parts of themselves which might be difficult to expose but which by the end of the activity, hopefully they would have built up enough trust to do so.

The activities in this session included swinging statue game, pairing off - with each person taking turns being a lump of clay to be molded, or being a sculptor molding the person into their image of them. The third part of the session was chanting.

Throughout the sessions at Daycare chanting was actively used, much more than at Dayhouse. It appeared to allow a physical release and forced people to use their voices which in their drugged and often submissive state, they seldom used. The evocative power of this particular activity was demonstrated in this session (October 20):

> D. commented that in actually making these sounds and having permission to feel like being a child again, he remembered quite a lot of incidents and the feelings that went with them and it made him frustrated and angry....
>
> J. said that remembering being a child to her was a terrible experience and that it made her extremely angry and she didn't want to think of them at all.
>
> In the war chant, I. was the most vocal of the lot, even though other people were able to make rather fierce sounds, he seemed to get the most out of it and be able to express himself the most. He said that being able to get that sound out of his body made him feel more relaxed and that he could actually scream and turn loose with it.
>
> D. was able to get into his feelings of frustration and anger. He had quite a piercing, terrifying scream and I actually stopped the chant because I felt the intensity of his anger in the scream and didn't think that it was wise to take it too far in this particular session, that he would know that he would be able to express that....

After the initial period of two and one-half to three months, the therapist notes a number of times in her session descriptions that the group has become much more active as a group in terms of physical movement and response to the music. The music therapist, as well as the resident therapists, felt that a major reason for this was the music therapy sessions. These sessions activated the patients and because the sessions had been established as part of the routine of the program, new patients were introduced to a higher level of activity than previously existed. Another major reason for the change was the perception by the staff that the type of patients had changed from the earlier stages of music therapy. This may in fact be the case, but it is not supported by any of the data that was gathered for this evaluation.

The session on November 17 marks a point where the music therapist turns her attention to encouraging the increasing verbal activity of the patients.

> The group is beginning to be more verbal. There are about three patients in the program that seem to be at least trying to express themselves, so the activity planned was to encourage them to have a kind of symbol of how they were feeling, then talk about the actual symbol.

The activity chosen for this day was spontaneous music with a variety of instruments and then people in the group dividing themselves into an aggressive, loud, energetic group or a sad, quiet, calm one. Although the music therapist felt people came up with "very graphic descriptions of modes of behaviour or moods of people....", the music,however,was "difficult to listen to because it was spontaneous music and it's the first time we've done this type of thing". What this meant was because of lack of experience with the instruments, the discussion after was not an emotional response to the music but rather an intellectual one. As a result it was decided that activities should be planned on a three week rotating basis in order to give people time to become familiar with the activity or the instruments.

Once again, a week later when the sequence of three weeks of activities begins, the first part of which is a warm-up walk, the therapist notes that:

> I could not help in this activity but to think of several months ago when we first started this particular type of movement activity and the group was extremely resistent and very rigid and they found it threatening....This group is extremely active, everyone is usually able to get into the activities and make the most of it.

Throughout the activity which includes a mirror circle and mirroring with pairs, various individuals who have been withdrawn are noted for their activity:

> S. was very active in the sense that she always tried to do something fairly expressive, often even creative with the music, she concentrated both on what she wanted and on those outside of herself she was imitating which is something she found very difficult to do in previous sessions a few months ago.
>
> B., as he was imitated in the circle, was very reluctant to give up his leadership.

In the third session of this activity, video-tape was used to film the activities of the group and then play it back to the individuals. As in both the Dayhouse activities and to a lesser extent the workshop participants, many of the patients reacted very strongly, both positively and negatively, to seeing themselves on the screen. Once again the relationship between individuals' conception of their body and their general attitude towards themselves was raised.

> B. thought she looked crummy and she would do something about it, but she also thought that she could move nicely.
>
> G., his progress in being able to concentrate and stay with the activity is happening, but it's very, very, very slow and he always has to be reminded by myself through the activity to either initiate the other person or to keep his eyes closed or something.
>
> A. noticed about himself that he was always pruning and fixing his hair, fixing his moustache and thought that for himself that it was a nervous gesture and he would take time to correct it. He also got a lot of positive reinforcement about the way he was moving.
>
> G. mentioned that he felt that he could see the self-consciousness in the rigid body movements for himself and for other people, that when they felt nervous or self-conscious they would tend to tense up and not be expressive.

After Christmas, the music therapy group had two low key sessions including basic movement and mirroring, and listening to music and writing poetry, then reading poetry out to the group. In the second to last session before the control group started, the music therapist asked each of the group to bring a piece of their favorite music and play it for the group. They were to instruct the group in physical position to take when listening and then later on tell the group why that piece of music was meaningful for them. The idea was to give them "some control over the planning of the session without actually feeling like it was a total responsibility". The results indicated that this was a form of activity that could be integrated more frequently into music therapy:

> I felt that this was actually a new dimension in the music activities. I usually take so much responsibility for planning of the session and this session meant a lot to the patients and they themselves went on past the time allotted to music therapy, playing other pieces from the albums and talking about each piece, and going on with the instructions of having people dance or sit and listen or whatever.

To summarize the comments from the music therapist's notes, the Daycare patients over a period of time began to respond to the music therapy sessions by showing increased activity and responsiveness to both the music and to each other. The Music Therapy appears to have especially assisted patients who were extremely rigid, who enjoyed non-verbal expression or movement exercises, who had a great deal of repressed information about themselves that was bothering them (chanting), or whose voice or body image was negative. In terms of the patients as a group, music therapy appears to have motivated greater participation by some in the group and encouraged hidden leadership potential as well as creating an environment that encouraged supportive participation from members of the group.

Staff Comments About Patient Progress and the Role of Music Therapy

The staff at the Daycare centre were the most co-operative of any of the staff of the various institutions in which the music therapy was offered as part of this demonstration grant. The resident therapists participated in many of the music therapy sessions at the hospital. However, like the other places in which music therapy was involved, the staff were extremely rushed for time and had little time available to keep notes on the activities of the patients in music therapy, both in the music therapy sessions and in the general program as a result of activities in music therapy. Although the staff probably had a better on-going idea of how the patients were responding, we still have very little information from them. The material in this section is the result of a series of meetings between the staff at Daycare and the research assistant to discuss the effect of music therapy as they saw it on a variety of patients. These patients are not all the same ones which form the sample of twelve. The two therapists sitting in on the meetings are identified as Ja. and Jo.

I. Ja. His (I.) whole posture actually changed when he was in Daycare. His seating posture became a lot more relaxed and a lot less rigid.

Jo. He was very controlled and music therapy kind of helped him to let go with the spontaneity.

Ja. I guess this ties in with spontaneity, he began exploring his own behaviour around other people because he always acts in a very mannerly way, in a very acceptable way.

F. Ja. He fitted right into that kind of thing, and I don't see him as someone like I., in fact it's like the other way around, he at the other end of the scale, very loose.

Jo. Except that I think that it gave him an opportunity to be loose and it was appropriate and it was okay, and I think it kind of helped him let it out in an appropriate way instead of inappropriate.

R. Ja. I remember him being quite aggressive. I remember particularly that exercise where we had the rope, and during that as I remember he was very aggressive.

Jo. One thing I noticed about him in music therapy is that in the group he was also aggressive, and the group would confront him about it and he used to get quite angry and resistant, but I noticed that a few times in music therapy it was pointed out how aggressive he was and how it scared people and he seemed to accept that.

Ja. ...I think, to me, he really craved closeness with people, I think that's one thing music therapy did when he did partner exercises, that you have that touching and that closeness with all the members.

G. Ja. A lot came out. That was again that rope exercise. How unimaginative he was and yet he took such a, what would you call it superior, no, superior role in the group verbally. Domineering role and yet in that group he was passive.

Jo. Maybe it gave him a little insight....At first he was quite frightened and he was able to discuss it, but I think he did pull out of it more towards the end, at least in that exercise, in those sessions....He became less fearful.

W. Ja. Well, it did make him a little more spontaneous you know, less rigid. For him, a little was a lot, like I didn't see any marked change but it was change for him, he was extremely rigid when he first came. And he too had problems relating to women and so that contact....

Jo. But actually he was quite reluctant to become involved and he found it very difficult, because wasn't he the one who said that, you know what's the point. He's the one who tried to organize that thing about cutting it (MT) out, remember?....He liked things that you could see the end product. He was very concrete and the abstractness of some of the things we did in Music Therapy, he was reluctant to do.

Ja. At the end he actually got quite disgusted because we did something that required imagination, and he was never happy with the results, like he had done some thing and everybody gave him a lot of reinforcement, it was like a picture of home or something....

Ja. I think it really added to his own self-awareness, like he came across to me as an intellectual person in the way he relates to people and he showed me there is another side of him.

H. Ja. She was one of the persons who was reluctant to join in, she was quite inhibited.

K. Jo. He was one person who in many activities and groups was very withdrawn, but in music therapy he seemed to be much more animated, seemed to be less inhibited, and seemed to really enjoy it. But at times he was quite resistant wasn't he?

Ja. In music, refusing to do something.

Jo. Yes, but when he did it and was encouraged to he seemed to really enjoy himself. And there was some exercises where he emerged as kind of a leader of the group, which did not happen in any other group. I'm thinking mainly of the sculpture where he placed everybody and also when he did that rope thing? He was very much the leader.

Jo. It seems to me too that when it involved doing things with other people, communicating with them, he wasn't as animated and wasn't as outgoing except after that one time when he emerged a leader, but when you got people to do things on their own, you know like dancing on their own or whatever, he really came on.

Ja. One thing not really a change but I really think it helped his self-awareness. One thing at the beginning C. asked who was the loneliest person in the room and K. was chosen and he was really surprised, but I think it must have given him some awareness.

Ja. I did think that he became more spontaneous. I remember towards the end I think, I was sitting next to him and he was painting and writing poetry to music and he put all these images in, and it was as if he was just writing as his thoughts flowed, and that was something new for K.

G. Ja. He liked the music. Liked the instruments.

Jo. I was going to say minimal, but I think he got some enjoyment from music, yes. Actually, he did improve, because his concentration was very poor and initially, I remember he needed constant directions and near the end in music therapy, at times he could follow like when C. gave general directions, just now and then he would be able to follow without C. going over and saying, now remember to do this or something. So it seemed to help with his concentration. (A patient who had been in institutional treatment for many years and who was drugged).

Jo. Another thing with him about music therapy. It was after he started music therapy he announced that he played the piano and sang and it was after that that he went to the piano a lot and sang, and brought his drums and so forth ...and when he did sing he seemed very happy.

E. Jo. All I can remember is doing the pictures, the drawings to the music, and I remember each line or whatever was quite significant and heavy. This line represents my position in life or whatever, everything seemed to have meaning and great consequence and he'd try and explain that in great detail.

We. I think that it is significant that C. doesn't remember him and is there something about him as a person that would characterize someone who doesn't benefit from music therapy.

Jo. His resistance to any kind of treatment. His difficulty acknowledging that there is something wrong with him.

D. Ca. The chanting seemed to really get him in touch with the intensity of his anger....He did some incredible voice stuff and the other thing was I felt that he really used some of the activities of self-expression.

W. Jo. ....He has a lot of difficulty talking with people, and over activities and things he can relate, so in music therapy I think it helped him a lot to express his feelings, but he can't do it verbally.

Ja. He shines particularly in the individual exercises.

F. Jo. Music therapy loosens him up. He was resistent when he first started....He's a very intellectual person and had difficulty in relating and in the very last session he said that for the first time he really let go and enjoyed himself, a lot less self-conscious.

Jo. In one of the first sessions he had done a drawing in a box shape, and some people in the discussion group said "I felt like I wanted to add something but there's just no room"....In the end I think there was...something about his drawing and his drawings which was much looser and it left more room for people to get involved or comment or something.

Appendix A

M.T.E. STUDY

1. Patient Number:

2. Birthdate:

3. Sex: 1. Male
    2. Female

4. Date of Interview:

5. Date of Admission:

6. Programme entering:
    1. Day house
    2. Daycare
    3. Other:

7. Marital Status:
    1. Single
    2. Married
    3. Living Common Law
    4. Widow(er)
    5. Divorced
    6. Separated
    7. Other:

   Since when have you been in the above checked status?

8. Who was the first to get the idea that you should try this programme?
    1. My idea
    2. Psychiatrist or other physician referral
    3. Social worker, Minister or other professional referral
    4. Spouse
    5. Friend or other relation
    6. Parent
    7. Employer
    8. Former patient
    9. Hospital
    10. Other (specify):

9. Do you know anyone who has previously been involved in this programme?
    1. No
    2. Yes

10. Who referred you to this programme?
    1. General Practitioner
    2. E1
    3. E2
    4. W1
    5. W2
    6. VGH
    7. MPA
    8. Private Psychiatrist
    9. Former patient
    10. Other community professionals
    11. Other (specify):

11. How does your family feel about your coming into this programme? (Specify whether parent or own family).

	Parent	Spouse
1. Strongly recommend programme		
2. Like the idea		
3. Indifferent		
4. They don't like it		
5. Strongly resent it		
6. They do not know		
7. Divided		
8. Other		
9. Not applicable		

12. How old are your children?
    1. Up to 2 years
    2. 2-4 years
    3. 4-6 years
    4. 6-9 years
    5. 9-12 years
    6. 12-15 years
    7. 15-18 years
    8. Over 18 years

(e.g., 2-4 years means up to but not including 4, etc.)

13. How many children are you responsible for looking after?

14. How far did you go in school (# of years)?

15. What program did you complete in your education?
    1. Apprentice program (specify)
    2. Post secondary technical program
    3. University degree
    4. Post graduate degree
    5. Other (specify)

16. What are your present living arrangements?
    1. By yourself
    2. With parents
    3. Spouse (inc. common law)
    4. Friend
    5. Two or more friends
    6. Boarding home or hospital
    7. Other (specify)

17. Who are your close friends:

Name	How long known

18. How do you define a close friend?

19. Do you have enough close friends?

20. How many of your friends know you're in the program?

21. In general do you enjoy being with other people?
    1. Never
    2. Very seldom
    3. Frequently
    4. Almost always
    5. Always

22. Under what circumstances do you enjoy being with other people?

23. Are you presently employed? Yes No

24. Jobs held, beginning with most recent:

Job	Duties	How long

25. What was your father's job?

26. How much did you like your present (or recent) job itself?
    1. Liked very much
    2. Enjoyed most of time
    3. Sometimes liked it, sometimes not
    4. Didn't like it
    5. Hated it

27. How much contact with people did you have? (Social skills)
    1. None
    2. Little
    3. Just enough (satisfactory)
    4. A little too much
    5. Far too much

28. How much did you like the people?
    1. Liked them very much
    2. Liked them most of time
    3. Sometimes yes, sometimes no
    4. Didn't like them
    5. Hated them

29. Present means of support:
    1. Employed
    2. Parents
    3. Estate
    4. Welfare
    5. UIC
    6. Other (specify)

30. What was your income in the past year?

31. Do you have any savings or property? Yes No Estimate Value

32. Do you have any debts? Yes No

33. Have you been caught breaking the law in the past year? Yes No

34. If so, what was the offence?

35. Have you ever attempted suicide? Yes No

36. How many times in the last year?

37. Have you ever thought of committing suicide? Yes No

38. How many times in the last year?
    1. Once
    2. Few
    3. Often
    4. Very often
    5. Constantly

How? (if volunteered)

39. What treatments have you had in the past year?

40. Why did you become involved in the program?

41. How have your problems interfered with what you'd rather be doing?

42. What interests or hobbies do you take part in and enjoy?
    1. Watching TV
    2. Member of sports team
    3. Jogging, swimming, skiing
    4. Attend sporting events
    5. Camping, hiking, fishing
    6. Going to musical events, rock concerts
    7. Going to theatre, movies
    8. Individual hobbies such as photography, macrame, etc.
    9. Reading
    10. Drinking in public drinking places
    11. Playing musical instruments, singing, dancing
    12. Other (specify)

43. Tell me some things you like about yourself, strengths in your personality.

44. What do you think could be done to improve the program here?

MTE STUDY DISCHARGE INTERVIEW

1. Patient number

2. Date of interview

3. Date of discharge

4. Reason for discharge

5. How do you feel about the treatment you received here?

6. Did you feel that you gained more out of some aspects of the program than others? 1 Yes_____ 2 No_____

7. If YES what parts of the program?

8. (a) Did you feel that you were able to come closer to solving any of your problems?

   (b) If so, which ones?

   (c) What have you done to solve these problems (some examples of resolution)?

9. How much did you enjoy the following? How helpful/useful were the following?

10.	Did Not Part.	Enjoyed			Disliked		Helpful			Not Helpful	
a) Commitments	0	1	2	3	4	5	1	2	3	4	5
b) Exercises	0	1	2	3	4	5	1	2	3	4	5
c) Music Therapy	0	1	2	3	4	5	1	2	3	4	5
d) Recreation	0	1	2	3	4	5	1	2	3	4	5
e) Yoga	0	1	2	3	4	5	1	2	3	4	5
f) Folk dancing	0	1	2	3	4	5	1	2	3	4	5
g) Ward rounds	0	1	2	3	4	5	1	2	3	4	5
h) OT	0	1	2	3	4	5	1	2	3	4	5
i) Non-verbal	0	1	2	3	4	5	1	2	3	4	5
j) Discussion	0	1	2	3	4	5	1	2	3	4	5
k) Relative group	0	1	2	3	4	5	1	2	3	4	5
l) M and W group	0	1	2	3	4	5	1	2	3	4	5
m) Work projects	0	1	2	3	4	5	1	2	3	4	5
n) Weekly review	0	1	2	3	4	5	1	2	3	4	5
o) Outing	0	1	2	3	4	5	1	2	3	4	5
p) Special interest	0	1	2	3	4	5	1	2	3	4	5

11. Which groups did you feel were the biggest help in dealing with your problems?

12. The Music therapists used a number of different activities. Were some activities more enjoyable than others?

13. Were some activities more helpful than others?

14. What did you think of the last music therapy session that you attended?

15. What did you think of the one previous to the last?

16. What are your plans for the immediate future?

17. How do your plans relate to the problems you wanted to solve?

Appendix C

Attendance of Daycare Patients at Music Therapy Sessions

	Aug.				Sept.						Oct.					Nov.					Dec.					Jan.				
	6	11	18	20	3	8	15	17	22	29	1	6	15	20	27	3	12	17	24	26	1	8	10	15	29	5	12	19	26	
JU	X	X	X	X																										4
IS	X	X	X	X	X	X	X	X	X	-	X	X	X	X	X	X	-	X												16
FW	X	X	X	X																										4
RS			X	X	X	X	X	X	X	X	X																			9
GM			X	X	X	X	X	X	X	X	X	X	-	X	X	X														13
WF					X	X	X	X	X	X	X	X	X	X	X	X	X													13
HB						X	X	X	X	X	X	X	X	X	X	X	-													11
KB							X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X							17
GM							X	X	X	X	X	X	X	-	X	-	X	X	X	X	X	X	-	X						15
EM							X	X	X	X	X	X	X	X																8
JM									X	-	X	X	X	-																4
JB										X	-	X	X	X	-															4
DW											X	X	X	X	X	X	X	X												8
WA												X	X	X	X	X	X	X	X	X	X	X	-	-	-	X	X	X	X	15
FM														X	X	-	X	X	X	X	-	X	X	X	X	X				11
DD																X	-													-
RF															X	X	X	X	X	-	X	X	X							8
DE																		X	X	X	X	X	X	X	X	X	X	X	X	12
BO																		X	X	X	X	X	X	X	X	X	-	X	-	10
RB																		X	X	X	X	X	X	X	X	X	X	X	X	12
AA																			-	X	X	X	X	X	X	X	X	X	X	10
GR																			X	X	X	X	X	-						5
SH																			X	X	X	X	X	X	X	X	X	X		10
CS																						X	X	X	X	X	X	X	X	8
BM																								X	X	-	X	X	X	5
JW																								X	X	X	X	-	X	5

Status of Day Care Music Therapy Participants

	# Sessions	Pre-Int.	Post-Int.	Pre-16PF	Post-16PF
JU	4	X	-	X	-
IS	16	X	X	X	-
FW	4	X	-	X	-
RS	9	X	-	X	-
GM	13	X	-	X	-
WG	13	X	X	X	X
HB	11	X	X	X	-
KB	17	X	X	X	X
GM	15	X	X	-	-
EM	8	X	-	X	-
JM	4	X	X	X	-
JB	4	-	-	X	-
DW	8	X	-	X	-
WA	15	X	X	X	X
FM	11	X	X	X	X
RF	8	X	X	X	X
DE	12	X	X	X	X
BO	10	X	X	X	X
RB	12	X	X	X	X
AA	10	X	X	X	X
GR	5	X	-	X	-
SH	10	X	X	X	X
CS	8	X	X	X	X
BM	5	X	X	X	X
JW	5	X	-	X	-

Day Care: Dates for Music Therapy

Aug.	6, 11, 18, 20
Sept.	3, 8, 15, 17, 22, 29
Oct.	1, 6, 15, 20, 27
Nov.	3, 12*, 17, 24, 26
Dec.	1, 8, 10, 15*, 29*
Jan.	5, 12, 19, 26

Underlined = report available.

* Session held by Day Care Staff.

VI

VANCOUVER NEUROLOGICAL CENTRE

The Vancouver Neurological Centre

The Vancouver Neurological Centre is a private society operating with government funding to provide co-ordinated treatment for all possible ramifications of neurological impairment including physical, educational, social, employment, and emotional complications. Social workers, physiotherapists, speech therapists, psychologists constitute a treatment organization that functions in the centre but they also spend a considerable amount of their time visiting and doing treatment in the home setting.

Music therapy sponsored by the Health and Welfare demonstration grant has been providing weekly sessions to specially selected children. A total of eight children at the centre are receiving music therapy. Four were receiving it before the Health and Welfare funding, and were continued in treatment. Another four started receiving music therapy treatment in January in an attempt to have a controlled research situation. This will be discussed at a later point.

Music therapy has been used at the centre as the major service provided for developing interactive and play skills for young children. It is also the only medium at the centre which is considered appropriate for one-to-one therapy with young children. The children who are involved in music therapy all suffer from a variety of neurological disorders, including epileptic seizures and brain damage which manifest themselves in poor motor control, poor muscular development and various emotional and social consequences of such impairment.

The centre staff expects music therapy to assist in improved self-concept, responsive social behaviour appropriate to the situation and the therapist, and communication skills, increased spontaneity, and self-organization, impulse control, and relaxation.

The music therapist has described the music therapy sessions as being highly flexible in order to support fragmented attempts and successes in these areas, to reduce pressure when it becomes obstructive, and to make room for affective and creative possibilities within every activity. She says that many activities are deliberately structured to require co-ordination, aural concentration, initiative, imagination, or controlled responses to high stimulation.

The sessions consisted of dancing and/or playing instruments to recorded music; painting to spontaneous music created within the session; creating songs or instrumental pieces co-operatively; tackling demanding exercises on a particular instrument.

Staff at the Neurological Centre report that they view the information that music therapy provides as unique and valuable because of the spontaneity, motivation, and individual attention inherent in it. Conferences and informal discussions are the main connection between the various treatment staff and the music therapist. Although several have observed the occasional session and will listen to tapes of particularly significant sessions, they are rarely available because of the predominantly home treatment cases.

Research Evaluation

The research evaluation design was initially intended to be a case history examination of the children who received music therapy. This proposal was made because there was very little experience with the use of music therapy with children with neurological disorders, and the potential sample was so small that traditional psychometric tests and control group design would be inappropriate.

However, at the insistence of the research consultants to Health and Welfare, the music therapists agreed to have a control group and use some form of psychometric test. The social worker at the Neurological Centre was asked to get a matched pair for the four children in the treatment group. The pairs were to be matched on the basis of age, sex, and type and extent of impairment. All four who were selected for the control group would have been referred for music therapy, except for the fact that they lived too far out of town. This matching proved only partially successful, as it proved impossible to get a complete match. Table 1 gives the information on the matching of the children.

A lengthy questionnaire was developed (Attached Appendix A this section) which focussed on the child's relationship with his friends, schoolmates, parents, and his own personal development. The questionnaire was administered to the parents of the children both before and after the music therapy sessions, and to both the treatment and control group populations. The hypothesis to be tested was that, as a result of music therapy, the children would change towards a greater degree of sociability. It must be kept in mind that while this formal procedure was being followed, there was little doubt that it was in fact an inappropriate one, and would give little in the way of definitive results. This is in fact the case; the sample is too small and the total amount of contact with the children during music therapy is too little to have any lasting impact. These are issues that are discussed in the introductory section on research at greater length.

In addition, a consulting psychologist was hired to recommend a psychometric test. He recommended Cattell's CPQ which is the early childhood version of the 16PF. The reason for this selection was the wide use of this instrument and the high degree of reliability that had been established for each of the factors in the test. The CPQ measured the same personality factors as the 16PF and therefore allowed a comparison between those factors that changed in the 16PF as the result of music therapy, and those factors that changed in the CPQ. However, it proved impossible to use this test with the children because of their frenetic behaviour.

The questionnaire was coded and analyzed, but the range of answers and especially the small size of the sample made it impossible to present the data in any meaningful way. It can be stated that the differences that existed between children in the pre-test in regard to their level of contact with other children, their parents and adults, their behaviour and their attitude towards school did not change throughout the period that they were in music therapy. In addition, there was almost no individual movement in children that could not be accounted for by individual factors such as a change in medication.

There was some shift in the level of participation in musical activities in the treatment group that did not exist in the control group, but this was erratic. One child took part in musical activities less since he became involved in music therapy, one took greater interest at the beginning and then tampered off, and two were more involved in music. The greater involvement meant a greater awareness of music being played in the house or greater musical activity, such as singing more in the home.

Treatment group parents were asked whether or not their children ever mentioned their "sessions with N. or with the musical instruments". The answers received from the four parents are noted below:

> Likes N. very much,doesn't mention sessions (he's a quiet closed kid.)
>
> He talked about it more in the first half than now. Describes the activities as "I played the drum" and "I clapped".
>
> She liked it but she missed too many sessions due to sickness.
>
> He tells me what he played but he has to be asked, "I did something new" (accordian). He enjoys the sessions.

The treatment group follow-up questionnaire also asked whether the parents had observed any of the music therapy sessions and what was their reaction to them. All parents had attended at least one session. The reason that we asked for their responses to the music therapy was to determine whether this was receptive and would tend to reinforce the experience in the child's mind, or whether it was negative. Not unsurprisingly, the answers were all positive and are listed below:

> Looks like fun.
>
> That it was quite good.
>
> Delighted and intrigued by how the therapist follows the child's interest and how she controls and channels behaviour and how she sets limits but at the same time follows desires and interests.
>
> I enjoyed the sessions. My son enjoys the sessions and expresses this. It's good to see him happy like that.

The teacher's check list (Appendix B) was an attempt to determine whether the effect of music therapy carried over into the school setting (all of the children were attending special education classes in public schools).

The check list was mailed to the teachers of the eight children both prior to treatment and at the end of the treatment. The results of the check-list were similar to the questionnaire. The scoring differed more within each population than between populations, and there was no significant change that could not be accounted for on the basis of individual factors (one girl's attitude towards school became even more reluctant, but this was a result of her being informed by her teachers that she was going to fail the year)

One of the objectives that was established for each of the children was stabilizing their behaviour and lengthening their span of attention. As will be noted in the case histories, this was moderately successful with some of the children. However, the teacher's check list asks teachers to note the differences in attention span, distractability, and restlessness. In no case did the rating change for the better, and in one case, already alluded to, it deteriorated. The rating scale was a very simple four scale one, and it is conceivable that changes did occur but were so small as not to warrant a change of category on the rating scale (or the teacher simply did not notice it). However, since the special education classes are quite small, it is more likely that the rating scale is accurate, and the increased attention span did not carry over into the classroom settings but remained specific to the music therapy sessions. This indicates that the music therapy sessions were able to achieve a degree of rapport and interest on the part of at least three of the children that permitted some growth, but which had not become integrated or generalized enough that it was carried over into other areas.

The results of the questionnaires and check lists that we prepared did not indicate any change that was even large enough to administer a test to determine its significance. The main information that is available on the children who attended the Neurological Centre and who received music therapy is contained in the case histories. The histories are compiled on the basis of the notes made by the music therapist throughout the treatment period. There was no other observer on a consistent basis who can provide an outside account or verify the analysis of the child's reaction. The case histories are also less complete than they might have been if the research had focussed from the beginning only on the case histories as a form of assessment.

Despite the limitations of the case histories, they still provide some insight into the development of neurologically impaired children as the result of the use of music therapy. More importantly, they emphasize the very small changes that are often significant in the overall development of the child but which would not appear in any test as statistically significant. They also indicate that the total potential development of at least some of the children is severely limited.

Case History Number One

L. has suffered from grand mal epileptic seizures since she was three months old. Her seizures, sometimes lasting for an hour at a time, were not brought under control until she was four, and are viewed as the cause of the mental retardation and the neck-shoulder-hand tremors with which she is afflicted. Fine motor skills are impaired by these tremors and her speech is obstructed.

L. is seen as a timid and withdrawn child who lives in her own world. She displays little interest in things outside it. In her efforts to organize herself she is meticulous and compulsive. She perserverates and repeats patterns of behaviour and pieces of music continually unless stopped. Her parents understand her limitations and are adamant about L.'s ability to win a place for herself in the world by being lovable. They had patiently taught her to do many of the things appropriate to her age - both developmental skills, such as climbing stairs, and recreational activities, such as bike riding. They don't consider L. to have "problems", but are interested in improvment in all areas suggested by the music therapist - especially increased focus on her body and speech performance, and relaxation of her tremors.

L. had previously attended activity sessions at the Neurological Centre two years ago but since then has been receiving no treatment. She was referred to music therapy by the social worker at the Centre because he thought it would increase her self-esteem. However, she has, since her treatment at the Centre, obviously improved her social skills, and the music therapy then demanded and rewarded a constant use of these skills, which she had tended to get lazy about.

The music therapist's original evaluation centred on L.'s general lack of control in focussing her activities. Although L. tended to get totally involved in the sensations of her own movement and voice, she did not perceive and evaluate feedback from the sound to notice whether or not she had accomplished what she set out to do. When the session was structured to demand a specific task completion, L. would squirm, sensing both the possibility of failure and the lack of freedom in the situation - but she would try. Perceptually and physically she had a severe handicap in producing specific movements or sounds - but after about six sessions, L. chose to go back to some of the tasks she had much earlier been set to show that she had gained some control and clarity. For L. music therapy was to be directed towards increasing her span of attention, focussing her activities, encouraging planning rather than drifting, gaining control of her body (especially her hands), and increasing her self-esteem.

From the beginning, L. was extremely enthusiastic. At the first of her nine sessions she went into the room and began playing with the instruments while the therapist was still saying goodbye to the previous child. She was very hyperactive, moving from one instrument to the other, and finally spending some time on the xylophone. The hyperactivity was not extreme and she stayed with each instrument long enough to find its musical possibilities and to get some feedback from it.

At the beginning of the session, she was talking a lot, but mumbling in a way that could not be understood and did not demand any response. She was elated to find that the therapist could play familiar songs on the piano and would join in with the singing in a very full-throated way.

By the second session, she was directing much of her conversation right to the therapist, while looking directly at her. She headed straight for the piano and began playing and singing a song that she had heard on the radio. She would be in tune vocally but her hands would be playing at different tempos. Because her hands were moving so fast (an on-going problem of L. was control of her hands), the therapist tried standing behind her directing her hands. She reacted against this. In other sessions, the therapist made a game of chanting "slow-down" in order to get her to repeat and slow her hands down. Another strategy used was for the therapist to play on the piano with L. and play some pieces fast and others slow to encourage her to gain control of her hands by playing along with the music.

Because she had so little resistance, she would go along with any activity that was suggested, or would seem to randomly move on to the next activity without having thought through what she wanted to do. In an attempt to get her to plan her activities, the therapist would sometimes suggest that she stay seated after finishing one activity until she had chosen her next one. In the playing of instruments, it was set-up so that she would have to make choices, i.e., on the xylophone, she was told that she could only play one row and therefore would have to decide what row she was going to play.

She was also asked to alternate playing cluster notes with single notes. It was felt that the single notes demanded more physical control and therefore would help her gain some control over her body.

She was put on the drums for a structured amount of time each session, asked to copy playing one note, two notes, three notes. She did not like the structure but she would occasionally come back and ask to play the drums in that situation when she had her choice of activities.

A couple of times, she would play a song on the drums that she knew and would sing a song with Nancy. Although she would pause in the appropriate places when singing the song, she continued hammering the drums. This was connected to her inability to discriminate between and understand her own activities. Another example of this was her hammering the drum ten times and then looking pleased and looking for support after she had been asked to strike the drum only twice.

She enjoyed doing ensembles with N. but she could get involved in an activity and forget that N. was even there. A technique used by the therapist was to make a song about what L. was doing, in order to get her to view her activities from a distance and get some perspective on them. The nine sessions were broken by a month's absence by the therapist. L. however, was able to remember many of the lessons and activities she had done with N. and it was noted that she was trying to play the piano more slowly and to play single keys rather than a cluster of keys at one time. Another sign of the progress she was making was her willingness to admit to her mother that she had more trouble controlling her hands than her voice. This was the first time as far as anyone knew that she had given verbal recognition to this difficulty and was able to make comparative statements about it. It was felt that as a result of the music therapy she had become more conscious of taking control of her body, and had become able to influence the amount of body tension and tremor. Her activities also became less impulsive and the contact with music therapy reinforced her making clear communications with people rather than mumbling. The music therapist feels that the kind of activities outlined here would have to be continued and expanded very slowly over an entire year of regular meetings before she would be able to exercise a significant degree of control over her body.

Case History Number Two

M. is a ten year old girl suffering from cerebral dysfunction with retarded development, and possible autistic behaviour. Her symptoms are recurrent convulsion, perseveration, echolalia, delayed language development, clumsiness, distractability and moderate hypotonia. From the point of view of the Neurological Centre, her main problems are bizarre and manipulative behaviour, especially at home, short attention span, perseverative questions, echolalic utterance and hoarse voice. She also has clumsy fine motor co-ordination.

Her home life is complicated by her being the only child of a divorced mother who works full-time and is ineffective in her personal life as well as in dealing with her child's problem. Her marriage ended with a great deal of trauma; her husband, whom she hates, has visiting privileges with his daughter every three weeks.

M. has been under treatment almost continually for the last seven or eight years, beginning at the Vancouver Neurological Centre, then Maples, Laurel House and presently again at the Neurological Centre. Her mother is now investigating a residential treatment program at Cedar Hill just ouside of Nanaimo. The mother is receiving counselling from the Centre's social worker and assistance from other community agencies. M. is in a special education class in her school where she is unable to do anything because she can't concentrate, and as a consequence is left to do nothing.

The main concern at this point was to deal with M.'s impulsive activity and her poor concentration span. One manifestation of this is her continual non-stop repetition and asking of questions to people that she first meets, with apparent disregard for answers. The occupational therapist at the Neurological Centre referred her to music therapy in an attempt to slow her down sufficiently to do speech therapy with her. It had also been noted that whenever other children were aggressive, she was completely passive, and that the majority of her responses within social situations were with passivity. Her mother had reported that she was unable to spend more than a minute or two on any activity other than puzzles or flipping through books.

In the first music therapy session, she simply ran all around the room, touching all the instruments and running into other rooms to touch the toys. She was continually asking questions without waiting or listening for replies. The therapist was somewhat reluctant to push any kind of contact with her and therefore little communication took place between the two. The therapist basically ended up playing music for her.

At the next session, a record player was provided in order that there could be continual background music to provide some continuity in the session. Again, M. didn't play much and continued to ask a lot of questions. The therapist in this situation stopped her wandering, and made her stay in one place for sections of the session. It is interesting to note that the record that was played at this session continues to be the only record she wants played; even when she brings her own records from her house, when given a choice she will still ask for this same record. This is an example of a behaviour pattern that was repeated in different ways as part of her lack of acceptance of new toys or ideas.

By the third session she started to play the xylophone to the music on the record, but most of the session was still spent jumping from one instrument to another.

Throughout the first three and a half sessions, any voice quality is absent, and she speaks in a husky whisper. It is only half way through the fourth session that this changes. She started yelling with excitement when she realized that the therapist could play songs on the piano that she knew. As a result of this, they began having duets with N. playing and M. drumming. This was seen to be a significant shift because it involved her active participation rather than her passive involvement in the record, and therefore signalled an acknowledgement of her involvement.

By the sixth session, N. would play on the piano and M. would be on the drums. This was the first time there was any sense of her being involved actively in interacting with an instrument. She would get really excited and start jumping up and down and yelling, beating the drum energetically and laughing loudly, especially when there was some synchronization between N. and herself. This time, as she did on later occasions when she became excited, she would get up and move away or go to something else or just leave because the intensity of the experience was too much for her.

The first couple of times she left under these circumstances, the therapist would bring her back explaining to her that she was leaving because she was too excited, and would try to get her to remain in her place. After a while, it was possible to recognize when she was getting tense with excitement, and warn her to just 'stay here' before she actually got up to leave. This made it possible for her to begin to concentrate on staying before she had physically started to move and resulted in her remaining through the excitement on more occasions.

By the seventh session M. was making music for almost half the session without the help of the record. In the eighth session M. brought a feeling of stillness with her; she went straight to a very quiet (new) instrument and began playing it without a word. A few minutes later she seemed to lose interest so the therapist played one cut of a record. She didn't play much but continued making music after the record stopped for a full minute again without a word. It was expressive sustained music. Suddenly she had had enough and jumped up to go and touch things around the room. We listened back to the tape for the first time. She didn't appear to attend closely, but she was interested and asked for it again in the session. By the end of the session her voice was clearer and stronger, and direct in her questions and responses.

When they were in the piano duets, the therapist was able to notice greater flexibility than in her other behaviour. M. was able to change speed and tempo, recognize mood swings, and distinguish between fast and slow. During the duets, when speed and tempo and mood were being discussed, the high point of interaction between M. and the therapist took place. Although this was achieved on a number of occasions, there were also significant relapses.

Over the next five sessions M. had more moments of calm sustained music. She made increasing use of the therapist as a stimulus and accepted more structure. She still needed help sustaining an activity, but she could make good use of verbal reminders. Her speech is often more direct and less hoarse. She was increasingly affectionate with the therapist - reaching out, touching, saying "I love you" - often in the middle of a powerful musical ensemble.

On one of the final of the fourteen sessions she had, M. started acting out her anger and asked the therapist to act angry with her. She was screaming, yelling and got very excited when N. played at being angry with her. She had a hard time staying in one place during this session.

A typical session with M. lasted between 30 and 45 minutes, with 15-20 minutes spent playing solid music, in sections that eventually lasted as long as 7 or 8 minutes, but averaged 4 or 5 minutes. Ten-twenty minutes in each session would be spent in scattered non-directed behaviour, and 5 minutes spent just on questions. In most sessions, she would play two or three instruments. Progress over the fourteen sessions is seen in the increased attention span that M. has with the instruments, her concentration on a limited number of instruments at each session, the limitations on her perseverative questioning, and the ending of her asking questions about what to do next at about the time the piano duets started. A final indication of continuing progress was a very short four or five minute session when the therapist was on the guitar and M. played the rattle and drum. According to the therapist, it was one of the most peaceful times she had spent with M. and was the only time she seemed fully relaxed and at ease with herself.

Case History Number Three

C. is a ten year old child suffering from mild epilepsy. She has had petit mal seizures for the last three or four years and these have been under control since 1974. Her school wants to hold her back a year because of her poor attendance record which has been the result of these seizures. C. has a somewhat lower than average intelligence. However, her problems are not cognitive or perceptual, but personality.

Her mother seems to have high expectations of her, and is not easily impressed by C.'s efforts to win her praise. She is irritated by her stubborness and worried about her lack of friends, goals and initiative. C. seems to want and to look for praise, but her emotional response to difficulty is one of lethargy and lack of initiative. Previous treatment of her behaviour problems has been to put her into social activity groups to encourage her to be less withdrawn. She was referred to the Centre by her neurologist.

In her first music therapy session, C. was co-operative and imitative, although occasionally stubborn about what she wanted to do. She looked for permission to do things, and avoided spontaneous experimentation, waiting to find out the expectations and rules of the new situation. The therapist attributed this to her trying to find out who she was, and noted that C. tried to outguess her in being what she thought the therapist wanted her to be. Every activity prompted by the therapist led C. to choose some method of reflecting this behaviour of value back, rather than striking out on her own.

In the second session, the therapist tried to wait her out, and encourage her to participate in programming her own activities. When it was suggested to C. that she not echo the therapist, she would manage for only a few seconds before becoming imitative again. She couldn't be manoeuvered into being independent. When she was to lead in improvising music for the therapist to follow, she would, in effect, copy the therapist's previous notes rather than improvse her own.

Efforts to talk to her about the difficulty, but also the necessity, of making choices was slightly more successful in the third session. She still improvised only short pieces of music, and waited always for confirmation of her accomplishments. She would however make some choices, and improvise accordingly - she managed to hold a very simple predictable rhythm of her own. In this session, writing and drawing to music captured her fancy. She stuck to this activity for fifteen to twenty minutes and seemed to respond well to it - it was the kind of challenge she was used to. She made some suggestions and some ideas about what to do. Although slow in remembering a whole pattern well enough to repeat it and make it into a whole piece, she made persistent efforts to do so. She was very pleased with the therapist's praise and showed that she recognized and was satisfied with her success in this kind of clear-cut situation.

In the fourth and fifth sessions, C. tried to use different instruments, the violin, with which she was quickly adept, and the flute. She has an unusual facility for the mechanics of music. By the fifth session, she could work with both these instruments for ten to fifteen minutes, although with quite visible tension, since she had her own ideas about what was good. In spite of the fact that the flute, particularly, required great concentration for fingers and mouth, she persevered, and managed variations on what she had grasped. She seemed very proficient at the subtleties of 'fixing' bad sounds.

In all C. had ten sessions of music therapy, focussing for the most part on random and safe improvisation and on learning to master the flute and violin particularly. The therapist concentrated on encouraging C. to know herself and to state her own convictions, both in her choices, and in her ability to make the therapist aware of and respond to her lead. She encouraged C. to accept her real limitations, without inventing new problems, and to fulfil her possibilities and be responsible for herself. C. was encouraged to make most of the decisions in the sessions, with the therapist following her lead.

Like all kids, C. was very concerned with the notion of success and failure but she learned to acknowledge the tension she experiences when she is working with an instrument. By the end of the music therapy sessions, she was able to improvise for some twenty minutes a session and to articulate her feelings about what she was doing. She seemed very comfortable in the structure of the music therapy sessions.

Case History Number Four

Eight year old M. has been hyperkinetic since the age of three, and has a history of persistent over-activity, mood swings and distractability. As the result of a car accident when he was five, he suffers damage to the right hemisphere of his brain, resulting in impairment of his visuo-optical perception and weakness in his left limbs. His right/left distinctions are not established, and he falls over a lot on the playground. He suffers from migraine, asthma, and borderline mental retardation. His active performance however, matches his level of cognitive functioning, which tends to rule out the factor of possible emotional disturbance, but he functions below potential because of his distractability. He was referred to the Neurological Centre by his surgeon after the accident.

M. seems to have little sense of a through line connecting the end of an activity and all of its middle to its beginning and original impulse. He is constantly clowning around and seems to weight these antics equally in importance with the on-going tasks they interrupt. Musical continuity is therefore difficult. In any case, musical interaction seems less important to him than verbal communication, or physical manipulation of the instruments.

For the first five music therapy sessions, the therapist tried to encourage him to choose the combination of instruments to be used, but M. wanted the therapist to make the decisions andto structure activities clearly. He was more responsive if he was praised, but this showed only in his staying longer at an activity and not in his emotional response to the musical aspect of the activity. Although co-operative, his motivation remained low. He continued to prefer to use words as liaison between himself and the therapist, rather than the music, although here too his verbal communication tended to be fragmented and without any continuous line. He had no response to the sounds he made except to those which were loud and aggressive, such as beating the drum, and those which produced rather clownish sounds, such as the slide whistle.

By the midpoint of his sessions, M. was more aggressive and also more friendly, but also even less interested, with a much shorter attention span. He focussed on loud energetic beating and put a lot of energy into sustaining these sounds. This was one of the few activities he undertook by choice and in which he was not always testing the therapist. After six sessions, the therapist would have turned him over either to another therapist or to a different kind of treatment. His mother however wanted him to continue treatment, although she had little idea of what happened in the sessions. Treatment continued but without any clear sense of direction.

Appendix A

Information Sheet - Post

Name of Child: Date:

Mother (or guardian):

Address: Phone:

Same class/teacher as Before?

General health:

Special Diet?

Medications?

What program is your child involved with at the Neurological Centre?

What other programs or services is he involved with?

52. Has your child talked about his sessions with N. or with the musical instruments? Yes No

    If YES, what has he said?

53. Have you been involved with your child more in musical kinds of things? Yes No Explain

54. Have you ever attended any of the music therapy sessions with your child? Yes No

    If YES, what was your reaction to them?

1. How many children does your child consider to be his/her friend?
2. How many children does your child specially like or talk about?
3. Are there children that he/she likes but doesn't play with? Yes No

   If Yes, why doesn't he/she see these children?
   (e.g., distance, parental disapproval, antisocial behaviour)

4. How often did his/her friends come to the house in the last week?
   a) More than once every day
   b) Once every day
   c) On several days
   d) Once
   e) Not this week

Is this average? Yes No

5. In general how often do your child's friends play with him/her at your house?
   a) daily
   b) every couple days
   c) once a week
   d) two or three times a month
   e) very seldom
   f) never

Has this changed in the last 6 months?

6. How often does your child play with friends outside the home:
   a) daily
   b) every couple days
   c) once a week
   d) two or three times a month
   e) very seldom
   f) never

Has this changed in the last 6 months?

7. How often does your child have contact with other adults? (i.e., non-household adults, who he/she is close to)
   a) daily
   b) every couple days
   c) once a week
   d) two or three times a month
   e) very seldom
   f) never

Has this changed in the last 6 months?

8. In general what is your child's mood before going to school in the morning?
   a) very enthusiastic
   b) happy
   c) indifferent
   d) unhappy
   e) anxious
   f) other (specify)

9. What behaviours tell you how he/she feels?
   - a) expresses anticipation
   - b) hurries
   - c) dawdles till late
   - d) slow getting out of bed
   - e) complains
   - f) other (specify)

10. In general how does your child seem when returning home from school?
   - a) very enthusiastic
   - b) happy
   - c) indifferent
   - d) unhappy
   - e) anxious
   - f) other (specify)

11. Are there special arrangements for your child at school? Yes No

    If Yes, describe:

12. Do you feel the arrangements for your child at school are:
    Poor Satisfactory Excellent

    Why?

13. How often does your child talk about the teacher?
   - a) daily
   - b) weekly
   - c) seldom

14. Do you think that your child is having greater than average difficulty in school in the last 6 mo. compared to the first 6 mo.? Yes No

15. Do you think that your child will have greater than average difficulty in school next year? Yes No

16. Do you think that your child will have greater than average difficulty in school in five years time? Yes No

17. Do you think your child will be independent when grown up? (i.e., be able to live independently, manage own affairs)
   - a) yes
   - b) no
   - c) not likely
   - d) unsure
   - e) don't know

18. Do you think your child will be able to hold a regular job?
    a) yes
    b) no
    c) not likely
    d) unsure
    e) don't know

19. Do you have any other worries about your child? (List)

20. Does your child appear to have any fears or fantasies that you're concerned about? (List)

21. Does your child have any behaviours or activities that you're concerned about? (List) (Emphasis on changes in last 6 mo.)

22. How much confidence does he/she have about physical appearance?
    a) none
    b) very little
    c) less than average
    d) about average
    e) more than average
    f) a great deal

    Has this changed in last 6 mo.?

23. How much confidence does he/she have about school (academic) performance?
    a) none
    b) very little
    c) less than average
    d) about average
    e) more than average
    f) a great deal

    Has this changed in last 6 mo.?

24. How often a week does he/she get upset when
    a) can't have own way
    b) can't do something (i.e., perform a task)
    c) doesn't understand something
    d) criticized

25. When your child gets upset, how does he/she show it?
    a) talks about it
    b) cries
    c) screams
    d) violence (damages, slams)

e) violence to people
f) violence to self
g) other (specify)

Has this changed in last 6 mos.?

26. How often does your child respond to the rules in your home?
    a) always complies
    b) sometimes complies
    c) generally ignores
    d) sometimes ignores
    e) always ignores
    f) other (specify)

27. Does your child have trouble eating? (e.g., poor appetite, fussy eater)

28. Does your child have trouble sleeping? (e.g., insomnia, nightmares)

29. Which of the following independent behaviours does your child engage in:
    a) keeps hands/face clean
    b) dresses self
    c) ties shoes
    d) brushes hair
    e) chooses clothes
    f) uses phone
    g) travels bus alone
    h) keeps room tidy
    i) purchases at store

30. How often does your child seek affection?
    a) often
    b) occasionally
    c) never

31. How often does your child respond to affection?
    a) always
    b) sometimes
    c) seldom
    d) avoids affection, physical contact

32. How do you know when he/she wants affection?

33. Do you have a particular time for closeness? Yes No
    (i.e., sitting together, holding, talking)

    If Yes, how often?
    a) daily
    b) weekly
    c) seldom

34. How often do you play games together? (e.g., cards)
    a) several times a day
    b) once a day
    c) every few days
    d) once a week
    e) 2 or 3 times a month
    f) very rarely

    Mother ____ Father____

35. How often do you read to your child?
    a) several times a day
    b) once a day
    c) every few days
    d) once a week
    e) 2 or 3 times a month
    f) very rarely

    Mother ____ Father ____

36. How often do you watch T.V. together?
    a) several times a day
    b) once a day
    c) every few days
    d) once a week
    e) 2 or 3 times a month
    f) very rarely

    Mother ____ Father ____

37. How often do you do housekeeping together? (e.g., cleaning, setting the table)
    a) several times a day
    b) once a day
    c) every few days
    d) once a week
    e) 2 or 3 times a month
    f) very rarely

    Mother ____ Father ____

38. When you go shopping how often does your child accompany you?
    a) always
    b) frequently
    c) sometimes
    d) almost never
    e) never

    How often do you dance, sing or play musical instruments with child?

    Has this changed in the last 6 mo.?

39. What other activities do you do together and how often?

40. In general how happy do you think your child is?
  a) very happy
  b) happy
  c) barely more happy than unhappy
  d) slightly more unhappy than happy
  e) unhappy
  f) very unhappy

41. In general how well liked do you think your child is by his schoolmates?
  a) very well liked
  b) pretty well liked
  c) liked a little
  d) met with indifference
  e) not very well liked
  f) extremely disliked

42. At home how much do you keep the radio on?
  a) most of the time
  b) some of the time
  c) occasionally
  d) never

43. What type of program do you listen to?

44. Does your child have access to a radio? Yes No

If Yes how often does he/she listen to it?
  a) constantly
  b) sporadically during day
  c) maybe once a day
  d) every few days
  e) once a week
  f) once a month
  g) less than once a month
  h) never

45. Does your child have access to a record player? Yes No

If Yes how often does he/she listen to it?
  a) constantly
  b) sporadically during day
  c) maybe once a day
  d) every few days
  e) once a week
  f) once a month
  g) less than once a month
  h) never

46. Do you buy records for him/her? Yes No

47. Does your child dance, sing or tap rhythm to radio/record player?
Yes No

48. Do you play any musical instruments? Yes No

If Yes, what? How often?

Has this changed in the last 6 mo.?

49. Does your child play any musical instruments? Yes No

If Yes, what? How often?

Has this changed in the last 6 mo.?

50. Does he/she engage in any other music related activities? Yes No
(e.g., choir, folk dancing)

51. Which three words describe your child's usual mood/behaviour in the home?

withdrawn calm lonely silly patient excitable destructive
happy warm negative sad bored cooperative aggressive
affectionate helpful complaining energetic irritable stubborn
fearful optimistic

Vancouver Neurological Centre Music Therapy Program - Personal Data Sheet

Name: Age: Birthdate: No. of Sessions:

1. Clinical diagnosis of child:
2. Problem/goal list:
3. Physical problems (e.g., motor skills, vision, etc.):
4. Medication/special diet:
5. Family background (siblings, any with problems or had therapy?):

Name	Sex	Age	Problems?

6. Parents (occupation, accomodation, how involved are they in the program? etc.):
7. Who referred the child to the Neurological Centre?
8. Previous treatment for behaviour problems?
9. How does their disability affect them socially? (a/c to social worker)

Appendix B

Teacher Checklist

Child's name:
Date:

A. The following is a list of problem behaviours. Please rate the child in question by checking the frequency rating which applies to that child as you know him or her.

	Never	Seldom	Often	Very Often
1 Prefers to play alone				
2 Speech is awkward or hard to understand				
3 Can't initiate own activities				
4 Shy with teacher				
5 Shy with peers				
6 Oversensitive to criticism				
7 Fails to finish projects (given or self-initiated)				
8 Irritable				
9 Timid, never makes first approach				
10 Defiant				
11 Seeks attention excessively				
12 Rigid and/or tense				
13 Unassertive about normal needs or behaviours				
14 Excessive mood swings				
15 Overdependent on others for assistance				
16 Tries to boss others				
17 Destructive				
18 Responds to teasing with tears				
19 Refuses to take turns				
20 Short attention span, distractable, restless				
21 Irritated if can't get attention				
22 Has no ambitions or interests				
23 Oversubmissive				
24 Expects to fail				
25 Anxious				
26 Jumps from one activity to another				
27 Does not share with others				

28 Is violent towards others (incl. spitting)
29 Appears to daydream
30 Has tantrums when can't get own way
31 Doesn't pay attention to directions/requests
32 Obnoxious with peers
33 Excessive frustration over failure
34 Withdraws when can't have own way
35 Objects to receiving a direct order
36 Misunderstands directions
37 Makes inappropriate remarks or rambles
38 Unable to take responsibility for failure (e.g. blames others)

B. In general, how happy do you think this child is?

(a) very happy
(b) happy
(c) barely more happy than unhappy
(d) slightly more unhappy than happy
(e) unhappy
(f) very unhappy

C. In general, how well liked do you think this child is by his/her school mat

(a) very well liked
(b) pretty well liked
(c) liked a little
(d) met with indifference
(e) not very well liked
(f) extremely disliked

VII

BURNABY MENTAL HEALTH CENTRE

Burnaby Mental Health Centre

Burnaby Mental Health Preschool Plus is a daytime treatment programme for emotionally disturbed preschool children. The Centre runs on the basis of the school year and the school day, but additionally, has a summer programme. The music therapists started working at Preschool Plus in the summer of 1975. During that period of time, they worked with 24 children on the basis of weekly twenty minute sessions in groups of four. Treatment goals were generally to encourage self-expression, social interaction and response to others. Individual goals for each child were also decided in conjunction with the staff.

The information from the summer programme was lost to the evaluation research when the research assistant quit in the middle of the summer and the test that was being used necessitated interviewer continuity. The staff requested that music therapy be made available during the winter programme, which had fewer children registered than had the summer programme.

The winter programme was structured in the same way as the summer programme, with weekly sessions lasting from twenty to forty minutes. The groups ranged in size from 2-4, depending upon the registration and attendance of the various children. The composition of the groups was deliberately varied each week in order that children could be grouped together in a way that would be most beneficial to the development of each child and the group. Children were grouped together on the basis of different factors at different points in time. Sociability was one such factor - sometimes sociable children were grouped together and at other times they were grouped with children who were more withdrawn, depending upon whether the therapist felt it was necessary to reinforce these social characteristics or offer encouragement and a model to children who were withdrawn.

Another factor affecting group composition was the interest the children showed in the music and musical instruments. The therapist sometimes felt it was necessary to group children who were especially interested or skilled in music-making so that they would enjoy the success of creating sounds together. Aggressiveness was a further factor taken into consideration in selecting groups. Sometimes, aggressive children were separated in groups from quieter children, at other times, these aggressive or hyperactive children were isolated in a quieter group.

These various factors were not isolated from each other, and so each group tended to weigh each of the factors differently, depending on what were perceived to be the needs of the children. Over a period of time, two different groups stabilized, with the remainder of the children floating between them.

The sessions consisted of dancing or playing instruments, creating songs or instrumental pieces co-operatively, and encouraging the children to become aware of others in the groups both personally and musically.

Research

The research evaluation was to consist of a checklist filled out by each of the therapists and by the research assistant as observer, pre- and post-Par Tests, and a music therapy team and staff combined resume for each child.

The checklist was primarily intended to record the activity in each session in order to provide some basis for the written report and the assessments done by staff and music therapists. The checklist was used in the preparation of the case histories which follow, but was developed too elaborately to be of any use in terms of systematic observation which would yield data that could subsequently be analyzed. Even though an observer was watching behind a two-way mirror, and each of the therapists recorded their observations on each child, the three groups met consecutively with no time available in between to do proper coding. Consequently, the amount of detailed information that one observer was able to keep on four children at a time, or the therapists were able to remember over the three sessions, was limited both in accuracy and utility. For this reason, it was decided not to do a detailed analysis on the checklist.

The original intention, as outlined in the introductory sections on research, was to use the CPQ test in order to measure the development of the children on the 16 personality dimensions. It was not possible to use this test because of the age of the children. The Par (Preschool Attainment Record), refined by Professor Doll, was used in its place. The author of this report notes that there is a paucity of tests which adequately assess the development of young children, particularly those with neurological or behavioural disorders. There are several scales for the measurement of intelligence, but these were not applicable to the nature of this evaluation. The author also notes the handicap in the administration of such tests caused by "various impairments to perceptual, communicative and behavioural performances. They also include orthopedic handicaps and sometimes cultural limitations, and these scales are principally directed towards the intellectual processes without overall evaluation of physical and social function."

The Par test was developed as a refinement of the Vineland Social Maturity Scale, and was prepared as an appropriate assessment for children entering Headstart programmes in the United States.

While the Par has not been normatively standardized in the same way that the CPQ has, it does permit comparison between children and development by a child. The present Par test provides:

> Eight categories of developmental behaviour morphology. For each category, there is one item for each age period. These are by half year intervals from birth to 84 months (7 years), or approximately to about first grade schooling. The purpose of the examination is to provide an assessment of children who are not readily accessible to direct examination because of sensory impairments, speech or language difficulties, emotional disturbances, neuromuscular embarrassments, resistance to examination cultural problems, and the like. The assessment provides a measure not only of what the child can do, but more particularly, what he actually does in his usual state. The procedure provides a descriptive picture of the children's actual attainments in terms of his usual performances. (Pre School Attainment Record, Edgar A. Doll, American Guidance Service)

This test allows a comparison both in terms of a child's development according to his age, and also against the score on the basis of the eight categories. In order for there to be any indication of progress in the development of the child, a change in the score achieved must be dramatic enough that it cannot be explained simply as a consequence of natural growth and development over a period of time. The expectation in this instance is that the score would have to vary consistently within one child's profile or between profiles - greater amount than the half year difference which would naturally result from the length of time over which the treatment took place.

The pre- and post-scores for each child are indicated at the bottom of their case history descriptions. It was obvious from a simple glance at the scores that there has not been sufficient change in any of these areas to warrant crediting either the treatment programme at Burnaby Mental Health, or the music therapy component with success as judged by this test. We had previously speculated that the major change because of the orientation of music therapy would be in the categories of Rapport, Communication, and Creativity. This was, in fact, not the case.

Appendix A. Case Histories of Children Attending Burnaby Mental Health

J. is 6 years old. In January, 1976, the goals of music therapy for him were to improve his expressive speech; his self-esteem; and his social skills and play activities.

> J. becomes assertive and outgoing in the musical session whereas he tends to whine and follow other children about in the classroom. It took him very little time to become comfortable in the activity.
>
> He seemed keenly aware of the group harmony and enjoyed session most when the entire group was involved, sharing leadership and initiation.

Par Test Scores:

A) Category:	Pre-Test	Post-Test
Ambulation	11-1/2	11-1/2
Manipulation	10	10
Rapport	9	10-1/2
Communication	6	7
Responsibility	8-1/2	9
Information	9	9
Ideation	10-1/2	11
Crativity	6-1/2	6-1/2

B) Items Passed by Age Periods:		
0.0-0.5	8	8
0.5-1.0	8	8
1.0-1.5	8	8
1.5-2.0	7-1/2	7-1/2
2.0-2.5	7-1/2	8
2.5-3.0	5-1/2	6
3.0-3.5	5	7-1/2
3.5-4.0	4	5
4.0-4.5	5	4-1/2
4.5-5.0	4	4
5.0-5.5	5	5
5.5-6.0	2-1/2	2
6.0-6.5	0	1/2
6.5-7.0	1	1

Age in Months:
- pre-test: 63
- post-test: 68

J. is 4 years old. When he began music therapy in October, 1975, his goals were to improve his speech and expression of feelings and to encourage his self-assertion and independence. He preferred structured activities to creative ones.

J. has very limited verbal skills and became actively involved in communicating through the instruments after one initial session of observation.

He often appears quiet and shy whereas in the music session he was assertive and often expressed aggressive and lonely feelings.

J. seemed ambivalent about accepting response through the music - sometimes he would be pleased with recognition, just as often he would withdraw when responded to.

Par Test Scores:

A) Category:	Pre-Test	Post-Test
Ambulation	13	13
Manipulation	8	8
Rapport	7-1/2	7-1/2
Communication	6-o/2	7
Responsibility	7	6-1/2
Information	7	9-1/2
Ideation	10-1/2	11
Creativity	7	6

B) Items Passed by Age Periods:		
0.0-0.5	8	8
0.5-1.0	8	8
1.0-1.5	8	8
1.5-2.0	7	7
2.0-2.5	7-1/2	7-1/2
2.5-3.0	6	5-1/2
3.0-3.5	7	7-1/2
3.5-4.0	4-1/2	4-1/2
4.0-4.5	3	4
4.5-5.0	2	1-1/2
5.0-5.5	1-1/2	3
5.5-6.0	2	2
6.0-6.5	1	1
6.5-7.0	1	1

Age in Months:
- Pre-Test: 46
- Post Test: 51

For 5 year old I., it was hoped the music therapy would focus on several basic goals: to improve his speech and social skills; to encourage verbalization and response to instructions; to reduce his manipulation of adults; to improve his self-motivation and attending to tasks and to encourage him to accept responsibility for his own actions; and finally, to improve his body awareness.

In the beginning, preoccupied, somewhat autistic, I., displayed little interest in the music and tended to perseverate on one or two instruments, with no variety in rhythm or tone.

After three months he began to be focussed in on the instruments and their sounds, remaining fairly isolated in his experimentation. At this time as well, we had reports from home that he was spending a great deal of time experimenting with instruments there as well. He also began to use the music corner independently at school.

Soon he was interested and happy to realize he was getting adult, then child response to his skill. He has continued in that direction and now maintains a fairly consistent relation to the group experience, both allowing others to respond to him and responding to others himself. He also is able to express a variety of moods and becomes envolved in rhythmic and tonal structures.

Par Test Scores:

A)	Category:	Pre-Test	Post-Test
	Ambulation	12-1/2	12-1/2
	Manipulation	9-1/2	9-1/2
	Rapport	11-1/2	11
	Communication	8	9-1/2
	Responsibility	11-1/2	11-1/2
	Information	9	11-1/2
	Ideation	11-1/2	12-1/2
	Creativity	7	7
B)	Items Passed by Age Periods:		
	0.0-0.5	8	8
	0.5-1.0	8	8
	1.0-1.5	8	8
	1.5-2.0	8	8
	2.0-2.5	8	8
	2.5-3.0	6-1/2	7-1/2
	3.0-3.5	8	8
	3.5-4.0	5	5
	4.0-4.5	5-1/2	6-1/6
	4.5-5.0	6	6
	5.0-5.5	4-1/2	5

5.5-6.0	2-1/2	3
6.0-6.5	1	2
6.5-7.0	1-1/2	1-1/2

Age in Months:
Pre-Test: 63
Post-Test: 68

C. is 5 years old. For him the goals of music therapy were to improve his receptive and expressive language skills, to improve his gross and fine motor skills, to improve his attention span and later, to reduce his resistance to adult expectations and requests. He knew very few words and was often incoherent. He and his mother were very interdependent and there was a considerable anxiety at his separating from her, which had improved a little by January, 1976.

C. approached the music sessions tentatively at first, doing a lot of observing, sitting and rocking while others played. He became interested in the social aspect of playing music together and started his participation.

He was usually quite satisfied and happy upon leaving the music sessions. His participation was constant both within the group and independently in the classroom music corner.

Par Test Scores:

A) Category:	Pre-Test	Post-Test
Ambulation	5	4-1/2
Manipulation	8	6
Rapport	7	7
Communication	5-1/2	4
Responsibility	7	5-1/2
Information	5	5
Ideation	4-1/2	4
Creativity	4	4
B) Items Passed by Age Periods:		
0.0-0.5	8	8
0.5-1.0	8	8
1.0-1.5	8	8
1.5-2.0	6-1/2	7
2.0-2.5	3	7-1/2
2.5-3.0	4-1/2	6
3.0-3.5	1-1/2	7
3.5-4.0	3	4-1/2
4.0-4.5	1	3

4.5-5.0	1	2
5.0-5.5	1-1/2	1-1/2
5.5-6.0	0	2
6.0-6.5	0	1
6.5-7.0	0	1

Age in Months:
Pre-Test: 49
Post-Test: 54

C. is 5 years old, clinically diagnosed with an adjustment reaction of childhood. He is hyperactive and aggressive. His October 1975 goals for music therapy included his being encouraged to follow instructions and program routine, to lengthen his attention span and encourage verbalization. In January, 1976, they were to improve his expressive and receptive speech and his ability to deal with his feelings, to encourage his self-esteem and to teach him to deflect his energy appropriately.

C. was a discipline problem a great deal of the time, constantly testing limits, demanding focussed attention from any adults through negative behaviour. He gave the double message of having a lot to express and yet hating adults so much he would never let them share any of his expressions. He seldom listened to other children, instead in constant motion with no time for others. He would pick up and play many instruments for a short time and then dismiss them by either throwing them down, or just running from one to the other. He often grabbed instruments from other children.

At one point he was sent out of the music room and his behaviour greatly improved in following sessions for quite a time. However he did eventually go back to his distracting activity.

He does use the music corner independently for release, but seldom sticks around to actually get into any deeper expressions.

Par Test Scores:

A) Category:	Pre-Test	Post-Test
Ambulation	13	14
Manipulation	9	9
Rapport	12-1/2	13
Communication	8	8
Responsibility	12-1/2	13-1/2
Information	10	10
Ideation	10-1/2	12
Creativity	7	7

B) Items Passed by Age Periods:

0.0-0.5	8	8
0.5-1.0	8	8
1.0-1.5	8	8
1.5-2.0	8	8
2.0-2.5	8	8
2.5-3.0	8	8
3.0-3.5	8	8
3.5-4.0	4-1/2	5-1/2
4.0-4.5	5	5
4.5-5.0	5	5-1/2
5.0-5.5	4	4-1/2
5.5-6.0	2	4
6.0-6.5	2	3
6.5-7.0	3	3

Age in Months:
Pre-Test: 56
Post-Test: 61

S. is 5 years old, suffering from an adjustment reaction of childhood. He is flustered by adults. His problem/goal list includes: improving his receptive and expressive speech and his social skills; reducing his anxiety and tension; and increasing his attention span.

There was a discrepancy between S.'s behaviour in the classroom and in the music room from the very beginning. In music he seemed not anxious, integrated with other children well, was comfortable -- all unlike classroom behaviour.

In the music sessions, he was assertive, happy, related well to children and adults alike, even when he was having extreme difficulty with scattered behaviour in the class. His musical skills were good. He sensitively sought responding to others, as well as freely expressing himself.

Within the classroom, he used the music corner drums primarily as a mechanism for release.

Par Test Scores:

A) Category:	Pre-Test	Post-Test
Ambulation	11-1/2	11-1/2
Manipulation	7-1/2	7-1/2
Rapport	9	9
Communication	7	7
Responsibility	12	10-1/2

	Information	9	9-1/2
	Ideation	9	9
	Creativity	5	5
B)	Items Passed by Age Periods:		
	0.0-0.5	8	8
	0.5-1.0	8	8
	1.0-1.5	8	8
	1.5-2.0	6-1/2	7
	2.0-2.5	7	5
	2.5-3.0	6-1/2	6-1/2
	3.0-3.5	7	7
	3.5-4.0	5	5
	4.0-4.5	3-1/2	3-1/2
	4.5-5.0	2	2
	5.0-5.5	2-1/2	2
	5.5-6.0	3-1/2	3-1/2
	6.0-6.5	1	1
	6.5-7.0	1-1/2	1-1/2

Age in Months:
Pre-Test: 49
Post-Test: 55

Four-year old M. was diagnosed as suffering from an adjustment reaction of childhood. In October 1975, when her music therapy treatment was begun, her goals were to be the reduction of her tantrum behaviour, the improvement of her expressive language skills, and the encouragement of self-help skills and her ability to follow program routine.

M. cried the entire first session, but came to enjoy the experience during the second session and continued to enjoy the music throughout. She takes her playing very seriously, always looks satisfied upon leaving the music room, interacts smoothly with both children and adults, takes time to explore and respond.

Par Test Scores:

A)	Category:	Pre-Test	Post-Test
	Ambulation	10-1/2	12
	Manipulation	9	9
	Rapport	10	10-1/2
	Communication	7	7
	Responsibility	10-1/2	10-1/2
	Information	10	10
	Ideation	10-1/2	10-1/2
	Creativity	7	7

B) Items Passed by Age Periods:		
0.0-0.5	8	8
0.5-1.0	8	8
1.0-1.5	8	8
1.5-2.0	7	7-1/2
2.0-2.5	8	8
2.5-3.0	8	8
3.0-3.5	8	8
3.5-4.0	5	5-1/2
4.0-4.5	4	4
4.5-5.0	4	4
5.0-5.5	3	4
5.5-6.0	2-1/2	3
6.0-6.5	0	0
6.5-7.0	1	1

Age in Months:
Pre-Test: 37
Post-Test: 41

Five-year old B. suffers from minimal cerebral dysfunction and secondary behaviour problems. In October, 1975, his problem/goal list included; increasing his speech and his co-operative play with his peers; improving his gross and fine motor skills, and encouraging his following instructions. In January, 1976, they included also increasing motivation.

B. appears to have been as unresponsive in the music sessions as he has for most of the treatment in the center. His resistence takes the form of convincing adults and other children to expect nothing from him.

Most of his behaviour during the music therapy sessions consisted of attention-getting gestures. He needed to have the undivided attention, especially of the adults in the room and created a play to appear needy and incapable.

One positive opportunity afforded in the music sessions was that he had an appropriate attention-getting time. However, usually when he got the attention, he would try to make all believe he was worthless and unimaginative, often reverting to merely imitating some other child's activity rather than creating one of his own.

On the other hand, he will engage in solitary activity in the music corner, outside the group experience for extended lengths of time now on a regular basis.

Par Test Scores:

		Pre-Test	Post-Test
A)	Category:		
	Ambulation	8	11-1/2
	Manipulation	8	8
	Rapport	10-1/2	9
	Communication	10	9-1/2
	Responsiblity	8	11
	Information	10	11-1/2
	Ideation	6-1/2	13
	Creativity	6	7
B)	Items Passed by Age Periods:		
	0.0-0.5	8	8
	0.5-1.0	8	8
	1.0-1.5	7-1/2	8
	1.5-2.0	6-1/2	8
	2.0-2.5	8	7-1/2
	2.5-3.0	6	7-1/2
	3.0-3.5	5	8
	3.5-4.0	4	5
	4.0-4.5	4-1/2	5
	4.5-5.0	3-1/2	3-1/2
	5.0-5.5	2	3-1/2
	5.5-6.0	1	3-1/2
	6.0-6.5	1	2
	6.5-7.0	1-1/2	3

Age in Months:
Pre-Test: 52
Post-Test: 57

Five-year old M. also suffers from an adjustment reaction of childhood, with soiling problems. In October, 1975, her goals in music therapy were to establish contact and relations with adults, to express her feelings and to improve her self-esteem. In January, 1976, encouraging her spontaneity was added to these.

> M. was always vacantly cooperative in the music sessions. She had no interest in making contact with any adult and limited her responses and communication on most occasions to other children. On a couple of occasions, this general pattern did not hold true and she did establish some connection to one of the therapists. But these limited breakthroughs were scattered and unpredictable.

In general she seemed very controlled, unable to free herself into expression -- quite inhibited. At times when she observed some of the other children who were less inhibited she seemed to be curious and interested, but seldom enough to motivate herself into meaningful participation.

Par Test Scores:

		Pre-Test	Post-Test
A)	Category:		
	Ambulation	13-1/2	14
	Manipulation	11	11-1/2
	Rapport	14	14
	Communication	10	10-1/2
	Responsibility	12	13-1/2
	Information	13	13
	Ideation	13	13
	Creativity	7-1/2	8-1/2
B)	Items Passed by Years:		
	0.0-0.5	8	8
	0.5-1.0	8	8
	1.0-1.5	8	8
	1.5-2.0	7-1/2	8
	2.0-2.5	8	8
	2.5-3.0	8	8
	3.0-5.5	8	8
	3.5-4.0	6-1/2	7-1/2
	4.0-4.5	6	6-1/2
	4.5-5.0	6-1/2	6-1/2
	5.0-5.5	6	6-1/2
	5.5-6.0	5	6
	6.0-6.5	4-1/2	5
	6.5-7.0	4	4

Age in Months:
Pre-Test: 55
Post-Test: 60

M. is 7 years old. His referral to music therapy was prompted by behavioural problems. His goals in October, 1975, were to improve his language skills and reduce perseveration, to increase his attention span, and to increase his ability to follow instructions. By January, 1976, they were to improve his motor skills and body awareness and his self-motivation and social skills.

In the beginning M. was very rigid and ritualistic in his movements and sounds, not listening to himself or others, but content to perseverate on one beat. With direction he began to loosen up somewhat and after four months engaged in more exploratory activity both in sounds and movements.

At first he feigned contact with others but gradually came to accept it somewhat and on a few occasions, ask for it -- something he does not do in other situations.

After the four months, he moved with some guidance through various instruments and came eventually to express a variety of moods, such as aggressiveness, sadness and playfulness.

He began listening to himself and others, as well as recognizing when he was being responded to and responding to other children himself.

Par Test Scores:

A) Category:	Pre-Test	Post-Test
Ambulation	12	12
Manipulation	13	14
Rapport	13	14
Communication	10	10-1/2
Responsibility	14	14
Information	12	13
Ideation	13-1/2	14
Creativity	8-1/2	8-1/2

B) Items Passed by Age Periods:		
0.0-0.5	8	8
0.5-1.0	8	8
1.0-1.5	8	8
1.5-2.0	8	8
2.0-2.5	8	8
2.5-3.0	8	8
3.0-3.5	7	7-1/2
3.5-4.0	6	6-1/2
4.0-4.5	7	6-1/2
4.5-5.0	6	6
5.0-5.5	7	7
5.5-6.0	6	6
6.0-6.5	4-1/2	6
6.5-7.0	4-1/2	6-1/2

Age in Months:

Pre-Test: 74
Post-Test: 79

vities such as sing-songs, so there was no other music program apart from these weekly sessions.

The therapists brought a complement of instruments every week - including rhythm instruments, sounding metals, stringed instruments, and wind instruments such as kazoos, harmonicas, slide whistles and simple flutes. These were spread out on the carpeted floor. A group of children would come in and sit in a circle until the therapists felt that each member was aware of the whole group, then each person chose an instrument - at first, one at a time; later, all at once - with the understanding that one could change instruments at any point. Those who weren't ready to participate listened and watched until they found an interest.

In the beginning, most children were not as involved with other children or others' sounds, as with their own body movement and manipulation of their chosen instrument. They were also concerned with determining the limits of this apparently expansive freedom. In many cases, their attempts to find censure were ignored by the therapists, while we strongly praised their positive explorations into the potentials and nature of their instruments and bodies. For the few who felt compelled to persist in evoking disapproval, we later made suggestions or curtailed that behaviour, always referring to needs of the group as a whole.

From the beginning, therapists provided a musical coherence to connect the sounds different children were making, even though few children tended to be conscious, yet, of sounds relating to each other. Also from the beginning, our musical focus shifted from group to individual and back to group - echoing, mirroring or elaborating on bits of sound, with or without eye contact, depending on each child's readiness to acknowledge personal contact. This fleeting ensemble offered a model of musical interaction which the children soon noticed and watched for, and even began to request (non-verbally) - though for about eight sessions, it was largely the therapists' initiative. At this point, the two therapists were still the only common focus of the group - attention mostly centered in one's own activity, yet each child became increasingly curious and attentive towards other children's activity. One of the first steps for the children in forming ensembles stemmed from covetting another's instrument and sharing it or picking up a similar instrument - thus creating an inherent connection between isolated explorations.

It was at this time - after eight sessions - that children began to reveal their inclinations for interaction, volume, activity and musical involvement. From then on, group membership was frequently shifted to regroup children who seemed to be at compatible stages and in complementary moods each week. (Also at this time, the pre-school parents and staff made instruments for the classroom and created a music corner which was available at all times and from which the staff deliberately kept a distance).

We began to structure periods in each session, since the children seemed to have satisfied their curiosity, established some relationship with the instruments, and were showing signs of curiosity and interest in each other's activity. We introduced activities in which the whole group was expected to respond to one child at a time - including movement, touch and vocalization, as well as instruments. Although the leading child was often shy, the group attention was compelling, and the response usually gratifying. The followers often initially resisted the concentration and recognition of others required, but they were generally cooperative, and appreciated the give-and-take of group attention.

This mutual recognition carried over into the less structured music, and the children began to listen to each other, and gradually to share their activity more openly. The sounds of the group became increasingly cohesive, as their skill and responsiveness developed. Often children would show surprise and pleasure when they suddenly found that the whole group was involved in a similar kind of music. As the children began discovering and exploring their own ensemble, the therapists could withdraw from the central focus of the group. Recently the therapists have alternated in taking the groups, since the children don't require so much individual attention. Now that they are more responsive to each other and are experiencing the relation of their contribution to the quality of their group experience, they will begin to structure their own group activities. This is in fact happening in the music corner in their classroom. There they expect, when one of them begins playing, that others will join them and appreciate the company.

Based upon the observations of the two therapists, a psychologist and staff of the pre-school some things learned by the children in the music sessions were:

-- to stretch out past safe, familiar experiences;

-- to stay in an activity when another child joins in without great anxiety;

- to notice and value an expressive moment, e.g., gesture sound;
- to forego attention-seeking in order to follow and enjoy one's own interest;
- to enrich an experience by acknowledging and enjoying it publicly;
- to ask someone to enrich your activity by joining in;
- to sustain an enjoyable co-activity;
- to invest concentration in an activity in order to make it interesting.

The therapists involved selected this particular approach to stimulating the integration of expressive and responsive behaviour because of its tremendous flexibility both in group dynamics, and in its musical responsiveness to fragmented participation. This model affords a fluid role for the therapist, a framework which can include many different levels of participation, a creative and organic group process stemming from and developing through the changing nature of its total membership, and an inherent stimulus and reward for increasingly social participation.

Submitted by Nancy McMaster,
Reporting her joint work with Carolyn Kenny
Appreciating the inspiration of
Michael Haynes, Paul Nordoff and Clive Robbins

Appendix C

Burnaby Music Therapy Attendance (Group 1,2 or 3)

	Oct. 14	Oct. 21	Oct. 28	Nov. 4	Nov. 19	Nov. 25	Dec. 2	Dec. 9	Jan. 6	Jan. 13	Jan. 20	Jan. 27	Feb. 3	Feb. 10	Feb. 17	Feb. 24	Mar. 9	Mar. 16	Apr. 6
BD	1	1	2	-	1	2	1	3	1	2	-	3	-	2	-	2	2	3	2
MS	1	2	1	1	1	2	-	2	1		3	2	1	2	1	1	3	2	2
MR	1	1	2	2	2	1	1	1	1	1	1	3	1	2	1	1	1	1	-
MH	1	2	-	1	2	1	3	3	2	3	-	1	3						
BG	2																		
CH	2	2	2	2	1	2	2	2	3	-	3	2	1	-	-	1	2	3	3
IC	2	1	1	2	2	1	2	1	1	2	1	3	3	-	2	3	3	1	1
CK	-	2	1	-	1	2	-	-	2	2	1	-	-	1	-	-	1	3	-
JK				1	2	2	2	3	3	-	2	3	1	-	2	3	1	3	1
SB					2	1	1	2	3	1	1	-	2	1	2	2	3	1	1
MM						1	3	1	2	3	2	1	-	-	-	-	-	-	-
JS							3	-	2	3	2	1	3	1	2	2	2	1	1
JL										1	3	2	2	2	1	1	3	2	3
SH												2	2						
SH														2					

VIII

PRESCHOOL FOR SPECIAL CHILDREN

Documentation of the Music Therapy project at the University of British Columbia Preschool for Special Children was accomplished in a 16 MM film sponsored cooperatively by the Department of Health and Welfare and the National Film Board.

This twelve minute film is available through the Department of Psychiatry, UBC, audio-visual section. The film is also available on video tape in the twelve minute form and in a half-hour version, which includes interviews with the therapists, the school psychologist and school director. It is entitled "Listen To The Music Makers" and illustrates music therapy improvisation techniques with children having various handicaps.